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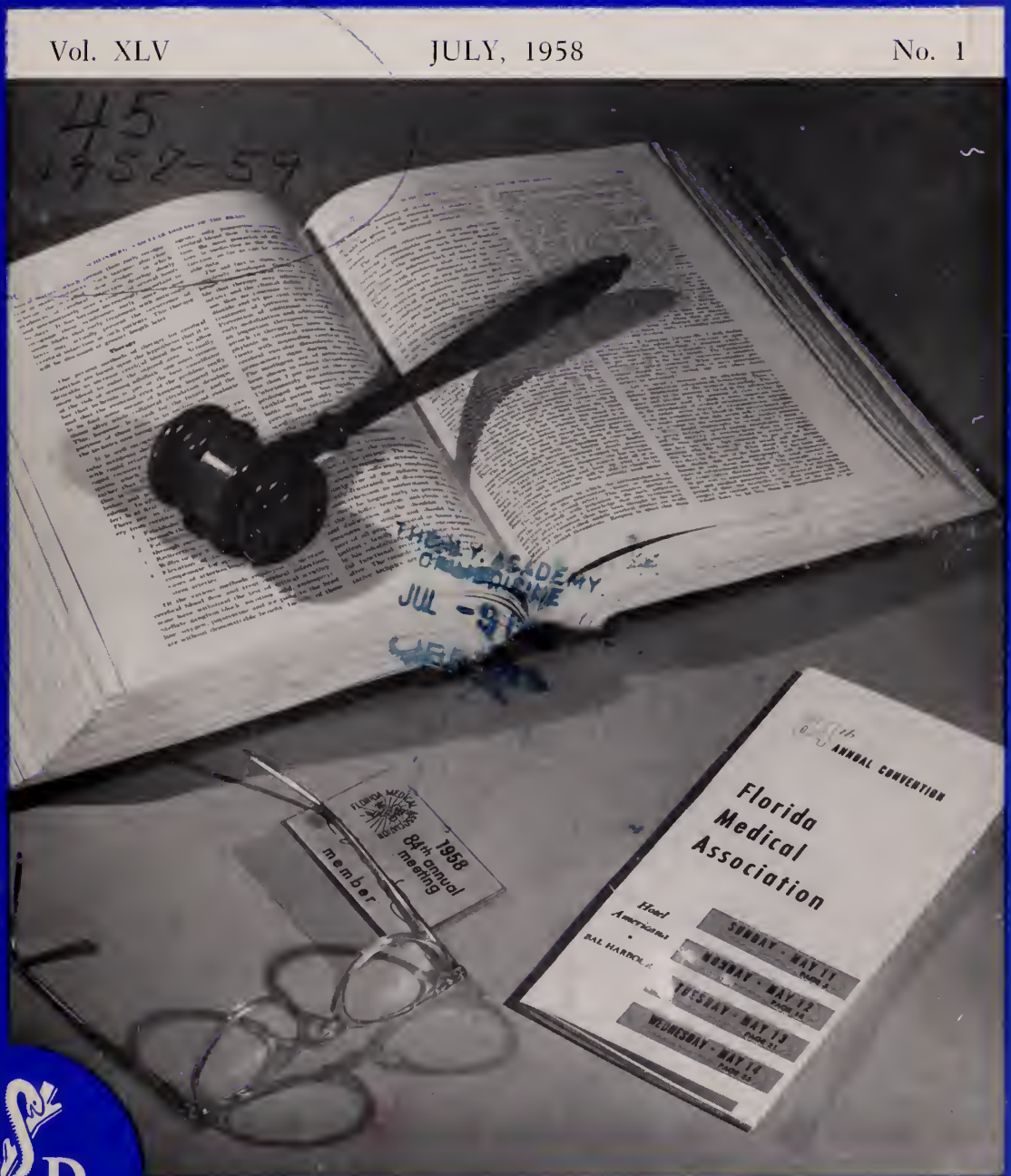


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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLV JULY, 1958 No. 1



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VOLUME XLV, No. 1 • *July, 1958*

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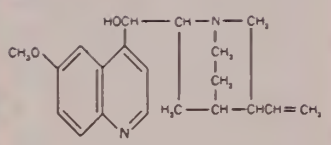
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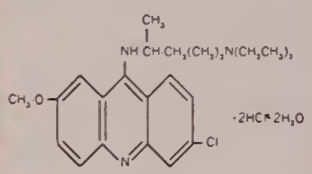
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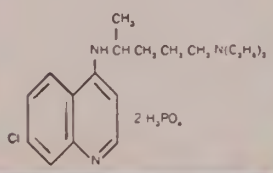
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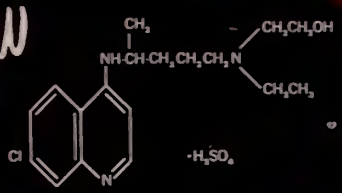
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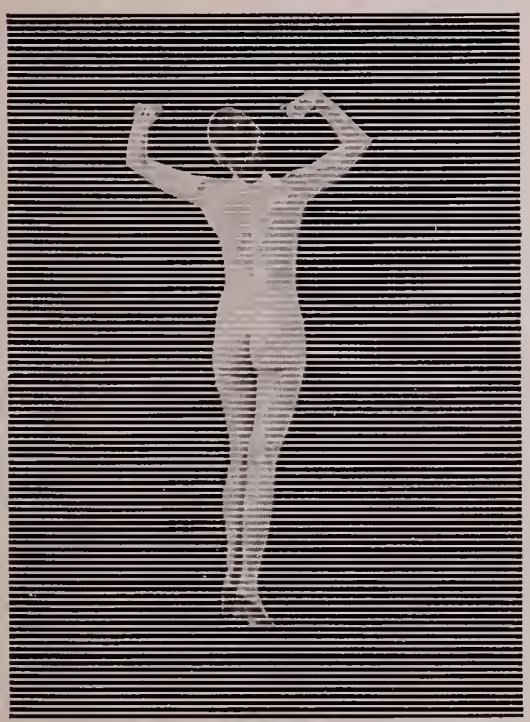
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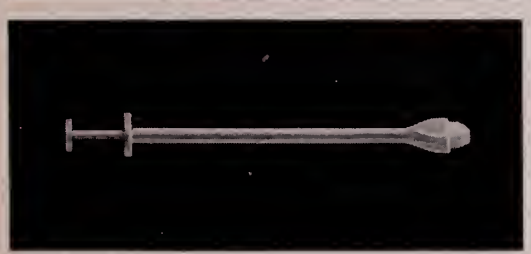
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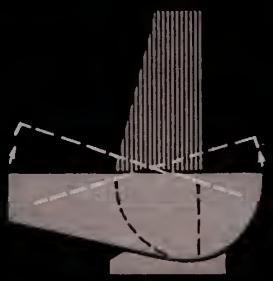
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1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812

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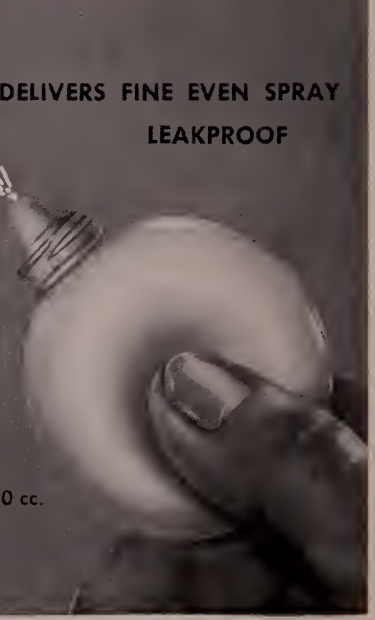
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The Journal of the Florida Medical Association
PUBLISHED MONTHLY

Volume XLV | Jacksonville, Florida, July, 1958 | No. 1

President's Address

William C. Roberts, M.D.
PANAMA CITY

First Vice President, Dr. Jack, members of the House of Delegates, other members of the Florida Medical Association, distinguished guests, most welcome visitors and members of the Woman's Auxiliary:

The Constitution of our great organization plainly states that the President shall deliver an annual address at a meeting of the House of Delegates; therefore, I will attempt to do so for three main reasons. First, I am grateful for the privilege; second, I want to express to you some of my thoughts, opinions and observations while serving as your President; third, I am eager to continue to try to carry out the duties of this high office by complying with this stipulation of the Constitution. In short, or in other words, this is a command performance.

Perhaps the most pertinent, necessary and desired information you might want from me about the various activities of your Association at this time is incorporated in the reports of the Board of Governors and other committees as published in the Handbook for Delegates, plus some supplementary additions to be offered later on in this session. I will not, therefore, impose on you by reiterating these items and this information for I know you have read, or will read, and study these reports, or accept or reject the recommendations of the respective reference committees to which they have been referred for study and disposition.

Since you saw fit to bestow upon me your highest honor by electing and installing me as your President, I want to say to you again that I am grateful, humble, and deeply appreciative of the gift. I have tried hard to prove to you my words are true. I have met with some success and some failure. The cloak of effort, however, is becoming threadbare and will soon be removed, but I have enjoyed every minute spent in serving you in this high office.

Now, since I am not a candidate for office, I feel free to speak. On the other hand, after I have spoken, I sincerely hope impeachment proceedings will not be brought against me before I can get that Past President's button on my lapel.

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 11, 1958.

In Appreciation

I wish to express my deepest gratitude to the other officers of our Association, to the Board of Governors, and to the committee chairman and members of each committee, for they have done their duties in a superior manner. Their attendance at the respective meetings has been most excellent. The fact that they have sacrificed much valuable time from their offices and defrayed their own expenses in most instances is surely most commendable. I personally appreciate their contributions and I feel certain the entire Association is equally as appreciative. If we do not thoroughly appreciate their sacrifice and effort, then my answer to the fine and germane editorial in the April issue of The Journal, entitled "Is It Martyrdom to Serve?" is-yes. If we do and demonstrate to them that we do, then my answer to the editorial is–no comment.

Particularly do I want to thank Dr. Henry J. Babers Jr. and each member of the Committee of Seventeen. They have worked hard and earnestly, they have spent much time, thought and money (their money) on this much discussed and controversial enterprise. They have tackled the study with an open mind, in a yeoman-like manner and with a bulldog tenacity. I sincerely hope their Herculean efforts will not have been in vain when this convention is adjourned.

With emphasis, I am grateful to Dr. John D. Milton and the Medicare Negotiating Team for their efforts in Washington in our behalf, and also to the state Medicare Mediation Committee. Theirs is a time-consuming, a nonstimulating and seemingly an unappreciated and thankless job. They try to keep us honest, but our dishonesty overwhelms them in many cases; at least, they try to prevent our breaking a federal law and perhaps suffering the consequences.

The members of the Council under the chairmanship of Dr. S. Carnes Harvard have experienced considerable activity this year. The problems they have encountered have been reconciled in a just and statesman-like manner. The District Meetings were planned and conducted in an admirable fashion, even if they did prove to be a sour note in our activity. With the efforts and performance of the Councilors I am most satisfied and to them I am truly grateful.

To our much loved, sincerely and deeply appreciated officers and members of the Woman's Auxiliary I wish to express my most profound and enthusiastic gratitude for their interest, efforts, inspiration and accomplishments. When God made man and put him in dominion over the earth, he readily realized he needed an auxiliary. After this was provided, the auxiliary soon was in dominion over man. This fact and trend have been manifested down through the ages. Every man needs a woman to care for him and make him strong for her to lean on. Give a woman an inch, and she immediately becomes a Ruler (and I do not mean a measuring stick); she becomes the boss, the dictator, individually and from a domestic standpoint. From an organizational standpoint, however, as the Auxiliary to the Association, our brightest and most worthwhile satellite, the situation is quite different. Give this organization an inch and it immediately becomes a yardstick (and I do mean a measuring stick). No task too small, no task too large, have we ever saddled upon its members that they did not negotiate with cheerfulness, willingness, speed, enthusiasm and satisfaction. Members of the Auxiliary, I again say to you—you are definitely needed and you are for sure appreciated.

The executive staff and personnel of the home office continue to do their duties in a bang-up manner. It takes a President to appreciate fully these individuals. They have made my yoke easy and my burden light, and I am most grateful.

To the Editor of The Journal, Dr. Shaler Richardson, and the entire Journal staff, let me say that you deserve continuing compliments, congratulations and high esteem for your product throughout the years. Our sincere appreciation and admiration, for your continuing to give us the finest state medical journal in the land, have not waned. In fact, our interest and enthusiasm for the official organ, the mouthpiece of our Association, is more manifest today than ever before. We must support The Journal individually and collectively to the utmost. We must give more thought and attention to this wonderful instrument of our organization for we may not be fortunate enough to have Dr. Richardson to head it for the next hundred years.

When we think of the Florida Medical Association, we think of its Secretary-Treasurer. Words cannot express our thanks, our compliments and our esteem for Dr. Samuel M. Day. Everyone knows that the key office of any organization is that of secretary. Ably serving in this capacity, Dr. Day may indeed be appropriately characterized as the keystone of the arch in the Association's official structure. Here again, I must ask you—is it martyrdom to serve?

The Association is an outstanding component of the American Medical Association, and since the national organization is the beginning and the end station to all our professional activities, to it we owe and profess allegiance. We are represented in this parent organization by our elected delegates. Our confidence in them has not been misplaced. In fact, they have been so outstanding and deserving that other state delegates have realized their capabilities and merit and have seen fit to place them on important committees. Yes, they plucked from among our outstanding delegates several years ago Dr. Homer L. Pearson Jr. and placed him in what I consider the highest position possible as far as power, respect and dignity go. He serves as the Chairman of the Judicial Council, which in understandable language means the supreme judge of the medical court of American medicine. The popularity of our delegates is indeed dynamic, and if my thinking is not completely off base. I feel certain the House of Delegates of the A.M.A. at the San Francisco meeting in June will pluck another of our delegates and bestow upon him the highest honor possible in American Medicine by voting him the President-Elect of the A.M.A. There is no doctor in the land more capable, more deserving and more willing to give his all, if need be, for the sake of organized medicine in this country than the present Vice Speaker of the House of Delegates of the A.M.A., our own Dr. Louis M. Orr, of Orlando. Drs. Reuben B. Chrisman Jr. and Francis T. Holland, our other two delegates to the A.M.A., have given an excellent account of themselves for several terms. I have seen them perform. Their performance is indeed wonderful to behold. All the A.M.A. delegates know Chris and Frank, and Frank and Chris know all the delegates, and be-

lieve me, they command much respect and are held in high esteem when the A.M.A. is in session and the wheels begin to turn. Yes, Dr. Pearson, Dr. Orr, Dr. Chrisman and Dr. Holland are indeed a compliment to themselves and to our Association, and I salute them as being the finest representatives in the A.M.A. any state medical association could have. The Association and the state of Florida are indeed more than proud of them.

There is nothing more valuable and useful than a spare tire, when and if it is needed. Our alternate delegates to the A.M.A., Dr. Richard A. Mills, Dr. Frank D. Gray and Dr. Walter E. Murphree, stand ready, willing and able to go into action if and when the occasion should arise. They deserve our utmost respect, admiration and thanks for their willingness, ability and stand-by attitude. No team can be considered strong unless it has capable reserves, and like any good football coach, we are proud and grateful for this all-American depth we have on our team.

I wish to thank the members of the Bay County Medical Society for their cooperation and support. Most especially do I thank Dr. Sidney E. Daffin of Panama City for his cooperation and help. Through his professional contributions I have been able to keep my practice intact and covered during my many absences therefrom. It is by virtue of his ethical spirit, thoughtfulness, understanding, willingness and charity that I have not lost financially, or in patient favor, from his efforts in performing my duties and shouldering my responsibilities where my patients were concerned while I was away and unavailable. That time, I may add, modestly and without regret, will amount to 89 days and two thirds as many nights when I return to my office from this convention, not to mention the two or three weeks it will take to attend the A.M.A. convention in San Francisco next month. To me he has exhibited the essence and acme of professional ethics and professional relations, the kind we all should practice and live. We are not associated in practice together; therefore, none but a true friend would be so willing or be expected to so oblige. I appreciate the pattern he has set. This example shall be a beacon for me to follow from here on out in dealing with my colleagues and contemporaries.

Needless to say, I am thankful for, and more than appreciate, my professional associate for the past 20 years, who is a guest of Mrs. Roberts and myself at this convention. She is my nurse-secretary, professional manager, and boss, my dependable crutch and my man, Friday. May the Lord forgive her for the many alibis and fibs she has offered in my behalf through the years. She is Miss Eula Marie Segler of Panama City. I would like for her to stand and be introduced to this House of Delegates.



Dr. Roberts

I want to thank the ministers who have complimented our profession in their pulpits and during their visitations with the sick and disabled. The senators, congressmen and legislators, and the press, who are our friends and have worked to our advantage, likewise deserve our appreciation. I am grateful to Governor LeRoy Collins, who, we know, is our friend and who demonstrates often that he has our interest at heart and that he has admiration and respect for organized medicine in Florida. To our attorneys, who have provided wise counsel and advice, steering us clear of unnecessary litigation and financial loss, we are most grateful. Our heartfelt thanks is offered to The Florida Bar for its spirit of cooperation in consummating the agreement between our two organizations for the sake of, and in the name of, justice.

There are many others, too numerous to mention because time will not permit, to whom we are indebted for their kindnesses and considerations.

Last but not least, in fact, first and foremost, I pay tribute to the presidential semi-widow and

your first lady this year, my beloved wife, Mary Ann, better known as "Pookie." She has accompanied me on many of my sojourns this year and has been a great comfort, as always, for which I am especially grateful. The discomfort she has caused is not enough to speak of, as if I dared. She has been my best advisor and my most impressive critic, the difference being bridged by love, devotion, companionship and sacrifice. When I was elected to this high position of responsibility, I told you then I would try to make you a good servant and I hoped Pookie would make you a good president. It is up to you to decide whether we have succeeded or failed. May I present my Pookie and your president, ex officio?

Purposes of the Association

Since we have just launched the eighty-fourth convention of this organization, I am sure all of us must recall the long line of distinguished physicians and surgeons who organized and developed the Assoication and who through the years since 1874 have made it a strong and useful servant of the people of Florida. Allow me to refresh your memory of Article II of the Constitution entitled "Purposes of the Association."

Article II — Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

This long sentence or paragraph contains many phrases and clauses and each phrase and clause bears much meaning. It had to be conceived and compiled by men of brains with afterthought, forethought and long range thinking—yes, dedicated men with integrity of purpose.

I want to use portions of Article II for my text, so to speak, a basis for some of my remarks. The doctors who wrote this Article lived by it, performed by it, and taught by it. They handed it down from doctor to doctor for at least three generations. I want to remind you now that the generation that sits under the shade of the oak is not usually the one that planted the acorn. I do, and I am sure you do, consider the implications of this Article a great heritage, but are we applying and are we complying with this heritage as we should and as those long before us intended for us to do? Our forebears worked hard and made great sacrifices in order to afford us our present day professional knowledge, dignity and prestige. I ask every member of the Association, individually and collectively, what are we doing with our heritage? What are we going to do with it?

Proper Organization

Let us examine the first clause of the article—"the purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida." To federate means to unite and not divide. For a long time before assuming office I had had a feeling that a large number of the members of our Association did not feel they were a part of the organization, except to pay the dues. They felt that they had no voice in the affairs of the Association and that it was run by a selected few. I surmised that perhaps this was the reason for the apathy and disinterest exhibited by so many. I made it my business, therefore, to try to find out if this attitude was true and if it was an influencing factor. In going among doctors throughout the length and breadth of Florida, and into two other states, I have learned that in a great measure this is true from their viewpoint, but it is strictly an alibi in most cases. There were some, however, who had a feeling they did not belong, and justifiably so at that. Occasionally one will find doctors who are peculiar characters, and I have run into them, who do not believe in organized medicine in any form. They wish to be let alone, to catch their best hold and do as they please. I sincerely hope this type of doctor in Florida will soon be extinct. Now, where does the fault exist? It exists in two places and with equal import or guilt, with the doctors themselves and with the county medical societies.

The desire to take an active interest in the affairs of organized medicine is overwhelmed by the desire to make a dollar. Motivated and captivated by selfish desires, these doctors forget their heritage, which gave them the privilege, knowledge and opportunity to work and prosper. They will not even take an active interest in their county medical society. They do not realize, and care nothing about, the importance and influence

the county medical society, the grass roots organization, has on the state association and its influence on their professional economy. As long as Joe will do it for them, they are content to ride on the band wagon that dedicated and sacrificing doctors cause to be propelled. Let the band wagon get detoured or disabled, however, and they are the first to howl and gripe. They cry out, what's wrong with the Association? Why does the Association not do something about it? They forget they are the Association and, in the majority of cases, the monkey wrench in the machinery. These do-nothing, let-Joe-do-it doctors in many instances are found among the older and well established members who have been in the Association for a number of years. I doubt if they will ever be changed. They must be carried along in the federation as part and parcel of the organization, but let us be vigilant lest their attitude become contagious.

The younger doctors practicing in Florida who belong or will belong to the Association are the ones we must federate and federate properly. We must reach them and go all out to influence them to take an active part in the affairs of their county societies and the state association. We must indoctrinate them as soon as possible and let them know that they belong. It is vital that we make known to them the values and advantages of organized medicine and their responsibilities and obligations to the profession, with a positive realization and a deep appreciation for their heritage, for they will be the steam and stamina of the profession in just a few years. They have visions, dreams, plans, inspirations and ambitions. They desire to become big professionally and economically in most cases. They must be influenced to realize they must share their ambitions with organization, and they must be influenced before they become greedy and callous and join with the do-nothing, let-Joe-do-it, apathetic, disinterested groups, lest their goals and future be thwarted and organization gone with the wind.

Yes, the lack of indoctrination is the other reason for this apathy and disinterest. Our present day organization or the lack of organization is definitely at fault in this respect. Even though I am in accord with the recommendation to do away with the District Meetings, let me say that this action is positive proof of the lack of proper indoctrination, and will only play into the hands of the apathetic and disinterested doctors.

It is appalling that some county societies have no By-Laws, and they are not just the very smallest societies either. Many are not incorporated. They all should have By-Laws in order to conduct themselves properly, efficiently and more progressively. They should be incorporated, not for profit, for the legal protection of the individual members. Both of these measures should be a must. The Florida Medical Association should require them, or very strongly suggest, or insist on the compliance of all component county societies in these matters.

Another word in this first clause of the article is "compact." "And bring into one compact organization" means to me close, dense, tight. In this age of great struggle, with political, social and economic discord in our nation, not to speak of geo-political animosities, differences and unrest, if we are to survive or even effectively spar with our enemies, we must have a tight organization. You may be sure that every organization which tends to shackle, divide, subjugate or destroy our profession is equipped with a tight and forceful machine, be it government, labor, industry, insurance companies, Veterans Administration, hospitals, or even churches, and I say to you now, our organization must be more compact than that of our adversaries. Wherever we have thwarted government control of medicine, we have stood compact as a unit. Wherever we have failed to stand compact, have quarreled among ourselves and have negotiated in separate groups, we have surely been taken over, and Medicare is an example.

Many today think organized medicine in America is sufficient. This is true from a structural standpoint; it offers the best. From the standpoint, however, of the integrity of each integral part, we fall short. With so many bypaths and inroads penetrating our midst, we are only exhibiting a holding action. We may be compared to the great Leonidas, the King of Sparta, at the Pass of Thermopylae, who, with his 300 Spartan warriors who looked upon him as their embodied hope of Spartan liberty, held back the myriad hosts of Persia. Victory was theirs until, alas, a traitor and a secret passage combined to cause them to be flanked and destroyed. We have just such traitors and many secret passages that will, sooner or later, appear on the socialistic horizon. Yes, we must make certain our back doors are not left ajar, lest we experience a similar fate in organized medicine. Tight medical organization is our em-

bodied hope for professional liberty. We must be certain of our position.

Education

Another phrase in Article II reads "with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education." With respect to this portion of our heritage, I believe we have kept faith. We have kept abreast and up to date in these categories. Our State Board of Medical Examiners, State Board of Health, scientific meetings, postgraduate education, and two fine medical schools offer positive proof to our forebears that we are standard or superior. These attributes of our organization, however, must be maintained and carried on with zest and zeal, with a view to constant improvement.

Political Activity

Two phrases in the Article—"the enactment and enforcement of just medical laws" and "guarding and fostering their (physicians') material interests"—have a bearing an each other. To preserve and better the implication of these phrases of our heritage, we must be concerned and take an active interest in politics. For many years, the medical profession has remained in a sort of shell of scientific absorption. The doctors are beginning to peer out of that shell, and hurrah for the venture, but most of us are reluctantly and timidly peeping out. We should gaze with penetrating x-ray and meaningful eyes if we are to learn what it is all about and become better informed. Medicine must abandon its old position of sitting on the side lines while members of other groups pull the political and economic strings that chart our profession and our nation's course. We must develop economic and political awareness which I, being an optimist, believe it is not yet too late to do. Some believe doctors should not engage in active politics, but just stick to treating the sick and injured, lest they damage themselves professionally and in the eyes of their patients, but I say to you, we should and we must. We must forget selfishness and choose the side of the issue we think is right and best for the profession and its application, and not only vote our beliefs, but work for our convictions. An unbiased opinion with regard to an issue in most cases is absolutely worthless. When one thinks he can see both sides of a situation, in most instances he sees nothing at all.

Yes, doctors should be active in politics, and why not? Since the beginning of this great nation of ours, doctors have contributed much in a political way. When the Mayflower landed at Plymouth Rock, among those who disembarked were two physicians. Our present way of life with its freedom and liberty began when George Washington marshalled the patriotic hosts of America against the hired minions of George III and won for us freedom and independence. This freedom and independence were soon followed by the creation of that engrossed document, the Declaration of Independence. Five physicians signed this great instrument of freedom. By coincidence, or otherwise, the second and third engrossed signatures on this hallowed paper were those of physicians. Up to now, 359 physicans have graced the halls of the Congress. Thirteen have been governors of states or territories. The first governors of Alabama, Delaware and Ohio were physicians. There are five physicians in the present Congress.

In addition to engaging in the practice of medicine, physicians have been judges, legislators, sheriffs and justices of the peace, and have held many other political offices. Yes, they have been mayors, and I cite two examples in the state of Florida at present, namely, Gainesville and Wewahitchka, no mean cities. Probably the most outstanding political figure among doctors in this country never held political office, but no doubt took great interest in politics. He could not have escaped this interest. He was Dr. John S. Harrison, of Ohio, who was the son of a President of the United States, and the father of a President of the United States. Yes, the political background of doctors is well established, and we should have no fear of participating in politics. We must revive this interest and make it a big part of our careers if we are to remain afloat and enjoy our heritage.

The political capabilities of organized medicine are tremendous, and if we would develop and use these capabilities—yes, throw our weight around—we would be able to cope with and have no fear of adverse political encroachment on our profession. If ever the science, art and economics of medicine, as we know it, love it, and wish it to be, become blighted, tarnished, degraded or disintegrated, it will be because of applied politics or the lack of it.

Politics in Florida and in this country should be right down the doctor's alley. We are taught, and we pursue every day in the course of the prac-

tice of medicine, the prevention of pollution and the eradication of corruption, and if I am not wrong in my thinking, politics is saturated with both. Yes, it is a most fertile field, and politics for sure needs us. It needs the kind of treatment capable and honest men possess, and I believe doctors are capable and I believe doctors are basically honest. The socialistic trend in this country is obvious and paramount. We have a big stake in it. We have much to lose. We, perhaps, have little to gain. Right now, the loss is about to submerge the gain. It is our challenge. It is up to you and up to me what effort we will bring forth.

Professional Conduct

Another phrase of Article II to which we should pay more attention is "the promotion of friendly intercourse among physicians." This to me means professional relations. Good professional relations beget good public relations. One of the things that has made our profession great, second to none, to ourselves and to the public, I am afraid is fast becoming a forgotten number. This is medical ethics—yes, simply the Golden Rule. The application and practice of sound and conscientious ethics will keep us cemented together more than any other influence. The flagrant disregard of good manners, one to the other, will do more to divide us than anything else. We must play fair and play by the rules. Be sure your sins will find you out and whatsoever a man soweth, that shall he also reap are both accurate statements.

The present time is an urgent time when we should rededicate ourselves to the practice of good ethics. We have hospital trustees arrayed against medical staffs, general practitioners against specialists, internists and diagnosticians against surgeons, the corporate practice of medicine against the private practice of medicine, and individual contract practice against the advice, principles, and endorsement of organized medicine. The differences here stem from monetary inequities and professional jealousies, I am sure. This unwarranted and uncalled for competition is a definite indication of the disunity among doctors and is becoming more apparent each day in the American medical profession. This disunity, this lack of harmony and cooperation, plus a strong disregard for the principles of medical ethics, is the influence that has brought about socialization of medicine in other countries.

To each his own, and without consideration and compassion for the other, the principles of medical ethics will become strained and to the point of rupture. This should never become manifest. When occasions arise whereby ethics must be applied, let us each appraise the situation sanely and in a gentlemanly manner and govern ourselves according to the dictates of a clear and true conscience. There is no other way to settle our differences properly. It has been said "the reason the United Nations have not met with more success is because they do not have enough united notions."

Public Relations

The last clause of Article II is "the enlightenment and direction of public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life."

We know that next to professional relations in importance is public relations. They both have the same initials, P R, and should be associated together. Every doctor in every community should take an active interest in social and civic enterprises and endeavors. Whenever possible, doctors should align themselves with religious, educational and civic organizations. They should certainly belong to their local Chambers of Commerce, and the State Chamber, if desirable. When eligible, they should join the American Legion and Veterans of Foreign Wars. Their influence and support may be the deciding factor when actions and opinions may affect our profession, favorably or unfavorably. Take an active interest and try to head up committees or be a member of those that pertain to the medical profession. We must be the informer and director of things medical if we are to have public opinion on our side.

Today, the three main reasons to disgruntle the public, our customers, in the order of their significance are: the cost of medical care, the availability of doctors, and the aloofness of doctors. Let us not be aloof; let us try to be available; let us charge reasonable and pleasant fees. If we can reconcile and compromise these factors, then we will have recovered some of our lost admiration, respect and dignity in the eyes of the public, which we so rightly inherited.

With reference to that portion of the clause that applies to the actual practice of our science

and art, no better slogan could we find to guide us than the inscription on the monument of Louis Pasteur in France which, when translated, means: "To cure sometimes, to relieve often, to comfort always."

Now, my friends and colleagues, if we will apply our time and talents through proper organization, education, political activity and professional conduct, both personal and scientific, with due regard for our fellow doctors and fellow men, with a passion and compassion for our customers, we can be like unto the mighty oak, the monarch of the forest, that furnishes shade for the herds and shelter for the birds. We can be the monarch of the profession, a beacon light for society and the humanities, a deserving recipient of our great heritage. Let me again remind you and beg you never to forget that if we are the generation that sits under and enjoys the shade of the oak, out of sheer appreciation for those before us and a deep consideration for those behind us, it is time we turned our thoughts and attention to the planting of an acorn.

In closing, may I emphasize that we are the only profession left that people have to trust? We make no affidavits; we offer no warranties or guarantees. We can only offer to those entrusted to our care encouragement or discouragement with reference to the result of our labors or the prognosis. Let us strive most earnestly with the help of Almighty God to continue to be trustworthy.

348 Cove Boulevard.

Board of Governors, Florida Medical Association For the Year 1958-1959



Members of the Board of Governors of the Florida Medical Association assemble for their first meeting of the year immediately following the final session of the House of Delegates of the Eighty-Fourth Annual Meeting at Bal Harbour. They include (front row, left to right) Dr. William C. Roberts, Panama City, Immediate Past President; Dr. Jere W. Annis, Lakeland, President; Dr. Ralph W. Jack Miami, President-Elect; Dr. Edward Jelks, Jacksonville, and Dr. Meredith Mallory, Orlando. In the back row are (left to right) Dr. James N. Patterson, Tampa; Dr. John D. Milton, Miami; Dr. Francis H. Langley, St. Petersburg; Dr. Reuben B. Chrisman Jr., Coral Gables, and Dr. Alpheus T. Kennedy, Pensacola. Not shown are Dr. Clyde O. Anderson, St. Petersburg, and Dr. Samuel M. Day, Jacksonville, Secretary-Treasurer.

We Can Help in the Cause for Peace

An Opportunity and a Challenge to American Medicine

Carlos P. Lamar, M.D.
MIAMI

"Our Indifference to Russian Gains Is Alarming—Terrible Truth: U. S. Survival Is at Stake. Rarely in American history have warnings so dire been voiced about the peril to this country. Expert testimony about Russia's mounting military might, and U. S. weaknesses, has come in recent weeks from respected military, political and scientific leaders . . ." (Top front page headlines and introduction to a series of articles by Bob Considine, The Miami Herald, January 5, 1958)

"The Friendly Russians—Ingratiatingly, alluringly, the Russians last week used the tools of trade and culture to turn Latin American eyes and aspirations away from the U. S., toward the U.S.S.R. The response (from both Brazil and Chile) gave the communists cause to take heart. . . ." (Time Magazine, January 6, 1958, p. 26)

The foregoing quotations are representative of the state of the world at the beginning of 1958. As members of the medical profession we are foremost concerned with problems of health and disease; as educated citizens we cannot remain aloof and ignore the terrible dangers which threaten our peace.

Because of our education and training, and because of our intimate contact with and relationship to those who trust their lives to us as patients, we can and we should, as individuals and through our established organizations, exert effective powerful influences upon the course of human affairs, not only at national, but also at international levels. Physicians, as most other men of science—and perhaps even more because of their essential constant concern for the welfare of their patients—are possessed of feelings of good will and friendship which overcome barriers of national borders, language and religion, as witnessed by the many international specialty societies and the World Medical Association. The language of medicine recognizes no frontiers. We are thus well equipped and able to help in many ways to promote the cause of peace and to protect ourselves against the indescribable perils of a Third World War. Because we are able, we have the duty to do so. We must become aware of our capabilities and of our great responsibilities. We must seek the means to fulfil them effectively and very soon, or it may be too late.

Many prominent public figures — our own Governor Collins and Senator Smathers among them—have repeatedly called attention to the fact that, in our leaders' preoccupation for restraining the imperialistic communist expansion in Eurasia, opportunities for developing strong and friendly defensive bulwarks among the Latin nations of our own hemisphere remain sadly neglected. Billions of our hard-earned tax dollars are spent in defensive projects boosting the development and the economies of peoples in Europe, Asia, and Africa. Only trickles so far reach our most natural allies and closest neighbors. While the Russians recognize the tremendous potential of the vast, enormous, undeveloped richness of those lands, and persistently woo their 225 million people with trade, cultural and educational offers, we still erect custom barriers against their vital exports to protect small segments of our economy at the expense of the majority. While the Russians maintain enormous and expensive propaganda machines under the guise of diplomatic missions, our own diplomatic and consular services operate there on antiquated and unrealistic budgets and programs.

It is about time that we recognize Latin America as a whole for what it naturally is: our greatest market and potentially our most powerful ally in the cause for peace and freedom in the world. Like us, Latin Americans suffered under colonialism and sought liberty through bloody wars for independence from European domination. Their democratic ideals and aspirations are the same as ours. Though some of them are still struggling for political maturity through dictatorships and revolutions, their own will and their great natural material and human resources are slowly gaining ground and some are already reaching high levels of stability, social justice and economic development. There is much that we, as a nation and as individuals, can do to help those still suffering growing pains in

order to speed their final growth into mature, stable and prosperous nations.

The effectiveness of Soviet propaganda versus our own relative inactivity is reflected in the fact that, though most Latin Americans look wistfully toward "The Colossus of the North" for aid and guidance in education and technical and financial assistance, there exists among them a feeling of frustration at our lack of real interest in their problems and at our relatively scant efforts in their behalf. To the less educated and poorer segments of their populations we are still the "gringo" who exploits their land and manpower, leaving little for them to enjoy. Those who are better off and able to travel and receive education in the United States become our best propagandists, but their numbers are relatively small. It is of tremendous importance to the future of our hemisphere and of the world that all possible means for bringing more and more of them into our country be explored and put into effect, not only because here they can obtain technical education so necessary for their countries' progress, but because exposing them to our environment is the best means possible to speed their political growth, while contributing to firmer bonds of friendship between our peoples, and neutralizing the Russian attempts to divide us.

As a starter, in an effort to become better acquainted with our neighbors' problems and needs and in seeking ways of aiding them, let us take the case of our closest neighbor across the Florida Straights, Cuba, which we helped liberate from centuries of Spanish exploitation in January 1899. History may someday recognize our well intentioned mistake in delivering Cuba to its own politicians on May 20, 1902, too soon, before giving them and their people a chance to learn how to govern themselves honestly and peacefully, as the major cause of the bloody revolts that have plagued the young republic since its birth. The history of each revolution in Cuba has shown that most of the idealist participants who survive each fight against the corruption and despotism of one government, once in power themselves, have become as corrupt and tyrannical or worse than the predecessor they had just defeated. In the struggle against oppression, great selfish tendencies develop. As long as the example of political amorality is all the victors remember, as long as rapid self enrichment is considered the natural consequence of victory, the chain of events will continue along the same deplorable paths.

The participation of some intellectuals, particularly teachers and students, in the current antigovernment activities in Cuba has resulted in the forced closing of all secondary public schools and the national university, with paralyzation of the intellectual progress and development of the nation. This, one of the most tragic occurrences in any country, might give us the opportunity to provide the means for the creation of a powerful catalyst which may change the course of history and give democracy one of its greatest victories, one which may develop more love and friendship among nations and raise the confidence and trust of the world toward us than all of the expensive propaganda efforts the Russians can display.

It is well recognized that only through education and exposure to a sound and true democratic environment can new generations of young men and women be inoculated with the principles of sound and honest democracy. Only young men and women thus enlightened would create in themselves the necessary moral stamina and the ambition to struggle, not for selfish personal aims, but for selfless, honest public service and for efficient public administrations which will provide political maturity and stability.

The closing of high schools and of the university in Cuba has forced into idleness a large group of intellectuals, most of them innocent bystanders, not direct participants in the political struggle. The individual frustrations resulting from the paralyzation of their educational pursuits can only be the source of further dissatisfaction and hate, with more and more of them participating in acts of sabotage and terrorism which bring on more and more government reprisals in a growing spiral, more and more bathed in blood. Those of us who have the opportunity of observing local developments closely feel nothing but pessimism about the outcome. As the situation stands in the present impasse, no peace, no stable form of democratic government seems possible for many years.

While all of this is going on, thousands of students, through no fault of their own, except the accident of their birth, are being deprived of an opportunity to acquire education and training which their country badly needs. Hundreds of university students, many in their senior year, just close to the day of graduation, see that dreamed of date move farther and farther away, with little hope of ever reaching their goal. A few are financially able to travel to other countries to com-

plete their education. They go mostly to Spain, where tuition and living costs are the cheapest, others to France, Argentina, Mexico and Venezuela. Except for those in Mexico, the political environment to which these students are exposed in their temporary exile cannot be considered ideal and conducive—at their return to Cuba—to contribute to the political maturity and stability of their own country. Very few so far can afford to come to the United States, not only because of the much higher tuition and living costs, but because of the many academic barriers of red tape preventing their admission to most of our schools.

The following plan, to apply specifically to medical students, could be extended to all others. It has been discussed by this writer with the deans of several medical schools in the United States who have received it with more than passing interest. Efforts to implement it are already being made by Dr. William W. Fry, Dean of Louisiana State University Medical School at New Orleans, who has expressed definite enthusiasm. Dr. E. S. Hamilton, Chairman of the Board of Trustees of the American Medical Association, and several other dean members of the American Association of Medical Colleges. But time is short and the need is great. These generous and interested men need help from all of us. This essay intends to present the basic intentions of the plan in order to stimulate thought and action, so that we may not have to hear again those dreaded words "too little and too late." This will not solve all of the world's problems in a jiffy, but no responsible thinking person can fail to see the tremendous possibilities for good that can be effected through this plan with relatively little cost and effort on our part.

In essence, the plan, to be applied first to medical students, could and should eventually be extended by the pertinent authorities and professional associations to other fields of learning. Starting with the Cuban group, at present in the highest need, it may be later continued in some modified form with students and graduates of other countries. The plan consists basically of the selection by a committee appointed by the American Medical Association and the Association of American Medical Colleges, of the best qualified senior medical students to be assigned on partial to full scholarships according to individual circumstances, at the rate of two or three to each American medical school participating, in order to give them an opportunity to complete their training and acquire the necessary credits toward their M.D. degree. This would be followed by one or more years of internship and residence training in approved hospitals. These students would agree in their contracts to return to their own country at the completion of their planned training period. Should conditions warrant it, the plan could be carried on farther to include students lacking two or more years of academic requirements for their degree. Previous experience has shown that language difficulties will not be great, as all primary schools in Cuba have carried English as a required subject for many years and all graduates have had two years of high school English. The majority of them can read it well and they usually speak and understand the language proficiently after a short stay in this country.

Assuming that these practical dreams could be put into effect in 1958, and that 150 to 200 students would be admitted each year under such a plan, from about 1960-1961 on, that many trained graduates would be returning year after year to their country, after two or more years of exposure to what we firmly believe to be the most democratic environment in the world today. Along with their medical training they would be obtaining the priceless experience of observing democracy in action in their everyday lives. They would be reading our free press, where open discussion is the rule and no man, no matter how high up in the government he may be, is ever immune to criticism. They would be comparing that with their own usually censored, suffering, ineffective press. They would watch our political fumbles and mistakes along with our generally honest and common sense approach to their solution through the peaceful means of the ballot. They would see examples of maladministration and of political graft, not through gossip, but in the limelight of public exposure leading to disgrace and imprisonment rather than to greater palaces, costly yachts and big foreign investments. They would watch our elections and the preceding campaigns and learn about public issues being openly debated rather than fought with guns and bombs.

They would learn that the great majority of our elected public officials are truly servants of the people, with all of the human frailties, but with sincere desire for and dedication to the good of the community. They would see many of these capable, honest men, devote their lives to hard

work and self denial for their country rather than turn to quick enrichment in private enterprise. They would make comparisions with their own standard, typical politician, who is used only to the idea that he would be a fool if he did not make himself richer than his predecessor in office. They would read and hear our grumbling about taxes, but they would also see how we generally pay our share in full, grateful that it helps to keep up free, while their rich men manage to avoid them as much as they can. They would, in sum, learn about civic responsibility, something which to many of them will be a new concept, seldom considered in their environment.

Could anyone envisage the worth to us in the United States of these hundreds of emissaries of good will leaving our shores to spread the gospel of our way of life to their own people? Could anyone appraise in terms of dollars what these young people would be able to do to elevate public moral standards and the standards of living among their compatriots? Is it possible to evaluate the return in friendly relations, even in cold cash business, the United States would receive back? Imagine the plan in operation for ten, twenty years, with thousands of professional young men and women, thus educated in decent democratic republicanism, exerting their strong influence in the affairs of their countries, forcing out corruption and graft, helping to establish sound political and honest administrative policies, knowing all the time, and telling their own peoples, how well these policies, despite our many pitfalls, have worked for our own nation. How else could we develop stronger ties of firm and lasting friendship and cooperation? How else could we better keep communism far away from our hemisphere?

The matter of accreditation at the return of these graduates to their own country could be amicably settled by negotiation with their own university officials. The financing of the plan could be managed by a combination of various possible ways: voluntary contributions from the great drug manufacturing firms in this country who have a stake in Latin American markets, from the great foundations, and from many civic groups. One of the first contributors should be ourselves, the American physicians. By a single dollar or two from each one of us throughout the country given each year, we could support about half the estimated cost of the program. What better way to do something for the peace of the world and the progress of the whole hemisphere? And, though our government is already heavily burdened with the cost of defense and our taxpayers can not be squeezed more, if necessary this writer would even call upon the Treasury of the United States to make a contribution. After all, the cost of the whole plan for three or four years would likely be much less than that of one single intercontinental ballistic missile. While we badly need better weapons for defense, we also need friends. We can think of no better investment than that which would help mold new generations of Latin American intellectuals into decent, honest and democratically enlightened citizens of their countries.

550 Brickell Avenue.

ABSTRACTS

A New Approach to Infant Feeding: The Use of Solid Foods and Three Meals a Day from Birth. Part I. By Walter W. Sackett, Jr., M.D. South. M. J. 50:340-342 (March) 1957.

This paper and the one which follows report further on the early introduction of solid foods into the diet of the very young infant. Dr. Sackett, who has so far had over 700 babies on the six hour feeding schedule he enthusiastically advocates, reviews this schedule and cites 10 of its advantages. He also cites five criticisms that have come to his attention regarding this revolutionary concept of infant feeding, none of which he finds valid.

Early Feeding Program: Part II. By J. E. Crews, M.D. South. M. J. 50:343-345 (March) 1957.

Dr. Crews relates his experiences with feeding infants solid food at an early age. He presents the program given mothers on their discharge from the hospital on their fifth postpartum day and reviews the instructions given them. In over 200 babies on a three-meal-a-day program begun on the second day of the infant's life while in the hospital he reports no complications due to early feeding. The growth of these babies and their development have been average or above in every instance. He concludes that infants who are fed solid foods at an early age generally have less colic and fewer feeding problems, are happier and more contented and seem more secure than when on a demand-feeding schedule. Also, he finds that the incidence of colds and infections of the upper part of the respiratory tract is definitely less in babies on this program.

Case Registry for Rheumatic Fever and Glomerulonephritis. By Milton S. Saslaw, M.D. J.A.M.A. 165:1129-1130 (Nov. 2) 1957.

The frequency of episodes of acute rheumatic fever and acute glomerulonephritis in the Miami area was studied by establishing a registry with the cooperation of more than 450 physicians and 13 hospitals. Monthly reports were obtained over a period of 13 months. During this period 17 acute attacks of rheumatic disease and 18 of glomerulonephritis were reported; of these, three of rheumatic disease and six of nephritis were reported in children aged six to nine. These low frequencies were striking in view of the fact that in the same age group a concurrent study of group A beta-hemolytic streptococcal isolation rates revealed the presence of these organisms in over 40 per cent of the throat cultures taken from children attending Dade County public schools.

Autopsies reveal a lower frequency of heart lesions due to rheumatic disease in persons born in Florida than in those born elsewhere. The method of case registry described in this article provides a means for comparing similar data collected in different geographic areas. Establishing similar registries in other parts of the country would yield valuable data as to geographic factors in disease.

Basic and Practical Radiography in Urology. By Benedict R. Harrow. Tr. Southeast. Sect. Am. Urol. A. 1957, pp. 111-119.

Holding the belief that the most neglected phase of urology is the radiographic science, Dr. Harrow urges urologists to take an active interest in roentgenology, learning and applying basic principles to actual practice. He points out that the importance of emphasizing a knowledge of radiology can be summarized by estimating that 50 per cent of urologic work involves diagnosis determined by radiology. He adds that the average x-ray technician has only a vague knowledge of x-ray variables and therefore in certain situations to produce better results urologists must be familiar with the variables so that they can be changed in the technic. While he makes no attempt in this paper to cover the entire radiographic field applicable to urology, he analyzes the radiograph from its four inherent qualities or properties: density, contrast, detail and distortion. To encourage further investigation into this field, he discusses certain basic concepts and presents practical suggestions.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.



















Proceedings
Eighty-Fourth Annual Meeting

Florida Medical Association
Bal Harbour, May 11-14, 1958

GENERAL SESSION

The Eighty-Fourth Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, May 12, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, by President William C. Roberts.

Invocation was pronounced by the Reverend Joseph E. Crawley, Pastor, St. Johns on the Lake Methodist Church of Miami Beach.

Dr. Roberts introduced Dr. Nelson Zivitz, President, Dade County Medical Association.

Dr. Zivitz: "Dr. Roberts, Members of the Board of Governors, Honored Guests, Fellow Members of the Association:

"I have come to learn that the duties of the President of the Dade County Medical Association range far and wide. Most of them are pleasant and rewarding. But none, so far, have given me as much pleasure as this opportunity to welcome the Florida Medical Association to Miami Beach and Dade County.

"The Florida Medical meetings are always thought-provoking, informative, and well organized. They are even more than that. Since the area of our state is so large and the number of physicians relatively small, each F.M.A. meeting is in the nature of a home-coming. Something akin to a Thanksgiving dinner where all important family problems are discussed and often solved. We are, happily, a perfectly normal family with many problems.

"Each time the F.M.A. has met in the Miami area there is an upsurge of medical enthusiasm. There is always the feeling that something new and exciting will be presented. There is also the knowledge that the old tried and true principles of medical practice will be presented in an attractive manner. The art, as well as the science of Medicine, is freely discussed to the benefit of all. This homey type of meeting is seldom found at other conventions.

"The Dade County Medical Association is delighted to be your host. We look forward to a most successful meeting and hope that you all will enjoy it so much that you will honor us with your presence again in the near future."

Dr. Roberts: "It is regretted that our first speaker, Dr. J. Rocher Chappell, is ill and cannot be with us today. In his stead, I present to you Dr. Wilson T. Sowder who will read Dr. Chappell's paper."

(Dr. Chappell's paper on "Civil Defense, Past Present and Future," will appear in a future issue of The Journal.)

Dr. Roberts introduced a fraternal delegate, Dr. Douglas L. Cannon, Secretary and Editor of The Journal, of the Medical Association of the State of Alabama.

Dr. Cannon: "It is kind of you to let me occupy your rostrum for a minute. I am delighted to return the courtesy that members of your Asso-

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Highlights of the Eighty-Fourth Annual Meeting

Members of the House of Delegates consider the recommendations of the Reference Committee on Blue Shield. (2) Dr. Arthur P. Richardson, Dean of the Emory University School of Medicine, accompany Dr. and Mrs. William C. Roberts, of Panama City, to the President's Reception Monday evening. (3) Dr. Nelson Zivitz, of Miami Beach, President of the Dade County Medical Association, delivers the Address of Welcome at the General Session Monday morning. (4) Dr. and Mrs. O. W. Hyman, of Memphis, Tenn., guests of Dr Roberts, attend the President's Reception (5) Dr. and Mrs. Roberts and Dr. and Mrs. Jere W. Annis, of Lakeland (left to right) are shown at the President's Reception. (6) Dr. Hyman delivers his address at the General Session. (7) In the ceremony near the end of the Second Meeting of the House of Delegates, Dr. Annis is escorted to the platform for his initiation as President by Dr. Herman Watson, of Lakeland; Dr. Edward Jelks, of Jacksonville, and Dr. James R. Boulware Jr., of Lakeland. (8) Dr. Roberts presents the gavel to Dr Annis, whose first official action was the presentation of the Past President's pin to Dr. Roberts (9). (10) Dr. Ralph W. Jack, of Miami, newly elected President-Elect, accepts the nomination.

ciation have conferred on Alabama from year to year. We were particularly happy to have with us this year your President and his charming wife.

"Alabama is your sister state; it is interested in the same problems that confront you.

"The doors are always open to you when the Medical Association of the State of Alabama is in session."

Dr. Roberts introduced his brother-in-law, President of the Shelby County Medical Society, Dr. J. T. Carter Jr., of Germantown, Tennessee.

Dr. Roberts: "Our next speaker probably should be introduced by some very high dignitary. He has been introduced so much that one of these days he is going to find out who he is. He has all of the qualifications that a man in his position should have. Without taking up his time, I want to present to you the President of the American Medical Association, Dr. David B. Allman of Atlantic City."

(Dr. Allman's address, "Is the Game Worth the Candle?" will appear in a future issue of The Journal.)

Dr. Roberts: "Our next speaker is a man whom I think holds a record of some kind. I have learned, and I think my statement is true, that the average survivorship of deans of medical schools is less than ten years. Since we now have two very fine medical schools in our state, I wanted to have as my guest speaker, a man who knows something about medical education. He knows something about everything. I think he has made only a very few mistakes in his life and one of those was about thirty years ago when he took me into his medical school. I want to say that I am very grateful for that opportunity.

"Dr. Hyman has been head of the College of Medicine of the University of Tennessee for 40 years or more. If you can show me another dean who has survived the trials and tribulations of medical school that long, we will give him the rose. I want Dr. Hyman to take as much time as he pleases and I want to give you Dr. Orren W. Hyman, Dean, University of Tennessee College of Medicine and Vice President in Charge of Medical Units."

(Dr. Hyman's address on "The Greatest Problem of Medical Education and Its Relation to Medical Practice," will appear in a future issue of The Journal.)

After a short recess to visit exhibits, the general session was continued with Dr. George T. Harrell Jr., Chairman, Scientific Work Committee, presiding.

Dr. David M. Hume, Richmond, Virginia, Chairman of the Department of Surgery, Medical College of Virginia, spoke on "Organ Transplantation—Past, Present and Future."

Dr. David T. Smith, Durham, N. C., Chairman of the Department of Bacteriology, Duke University School of Medicine, spoke on "The Role of the General Physician in the Changing Picture of Tuberculosis," which will be published in a later issue of The Journal.

The general session was adjourned at 12:45 p.m.

FIRST HOUSE OF DELEGATES

The House of Delegates convened at 3:00 p.m., Sunday, May 11, 1957, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with President William C. Roberts in the Chair.

The invocation was pronounced by Dr. Homer L. Pearson Jr., of Miami.

Dr. Roberts: "Dr. George F. Schmitt Jr., of Miami, is the Parliamentarian for the House of Delegates. He will be glad to advise any member on parliamentary procedure, and his advice will be available to the Chair. However, the Chair will make its own rulings, and I shall be just like Judge Bean, I shall say, that's my ruling."

Dr. Ralph W. Jack of the Credentials Committee reported that 160 delegates out of a possible 171 were present.

Dr. William M. Rowlett, of Hillsborough, moved that the delegates be seated.

Seconded by Dr. Carl S. McLemore.

Motion carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, G. Leonard Emmel
BAY—Wm. F. Humphreys Jr.
BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston
BROWARD—Norris M. Beasley, Julius F. Boettner, Russell B. Carson, Burns A. Dobbins Jr., Richard L. Foster, Anthony C. Galluccio, Walter J. Glenn Jr., John H. Mickley, Richard A. Mills
COLLIER—*(Absent—Daniel B. Langley)*
COLUMBIA—Laurie J. Arnold Jr.

DADE—Edward R. Annis, Morris H. Blau, John E. Burch, Chester Cassel, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Frederick E. Farrer, Richard M. Fleming, M. Eugene Flipse, J. Raymond Graves, Maurice M. Greenfield, W. Tracy Haverfield, Claude D. Holmes Jr., James J. Hutson, Christian Keedy, Robert P. Keiser, David Kirsch, Alfred G. Levin, Donald F. Marion, John D. Milton, Edwin P. Preston, Harold Rand, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Clifford C. Snyder, Chauncey M. Stone Jr., Wm. M. Straight, Arthur W. Wood Jr., Jack L. Wright, Nelson Zivitz

DESOTO-HARDEE-HIGHLANDS-GLADES — Gordon H. McSwain

DUVAL—Frederick H. Bowen, Hugh A. Carithers, J. K. David Jr., Lawrence E. Geeslin, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Edward Jelks, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, C. Burling Roesch, John T. Stage, Sidney Stillman, Leo M. Wachtel, Ashbel C. Williams

ESCAMBIA—Egbert V. Anderson, Paul F. Baranco, Pascal G. Batson Jr., Herbert L. Bryans, Joseph W. Douglas, Sidney G. Kennedy Jr.

FRANKLIN-GULF—John W. Hendrix

HILLSBOROUGH—Samuel H. Adams, Collin F. Baker Jr., Ernest R. Bourkard, C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., James N. Patterson, Wm. M. Rowlett, Wesley W. Wilson

INDIAN RIVER—Erasmus B. Hardee

JACKSON-CALHOUN—Grayson C. Snyder

LAKE—Fred A. Vincenti

LEE-CHARLOTTE-HENDRY—H. Quillian Jones, John S. Stewart

LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Francis T. Holland, George H. Massey, Robert H. Mickler, *(Absent—George S. Palmer)*

MADISON—*(Absent—A. Franklin Harrison)*

MANATEE—Millard P. Quillian, Willett E. Wentzel

MARION—Henry L. Harrell, Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—*(Absent—Benjamin F. Dickens)*

ORANGE—Chas. J. Collins, Duncan T. McEwan, Carl S. McLemore, Fred Mathers, Louis M. Orr, Frank J. Pyle, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert L. Tolle, Robert E. Zellner

PALM BEACH—Willard F. Ande, Charles McD. Harris Jr., Lorenzo James, V. Marklin Johnson, Ralph M. Overstreet Jr., W. Lawson Shackelford, Younger A. Staton, A. Scott Turk

PASCO-HERNANDO-CITRUS—S. Carnes Harvard

PINELLAS—Arnold S. Anderson, Clyde O. Anderson, Elmer B. Campbell Sr., Raymond H. Center, N. Worth Gable, Francis H. Langley, Jack A. MaCris, Norval M. Marr Sr., Orville N. Nelson, J. Braden Quicksall, Robert T. Walker, Walter H. Winchester, Rowland E. Wood

POLK—James R. Boulware Jr., Marion W. Hester, Coy L. Lay, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr.

PUTNAM—Grover C. Collins

ST. JOHNS—Herbert E. White

ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott

SARASOTA—John M. Butcher, Karl R. Rolls, Melvin M. Simmons

SEMINOLE—Wm. V. Roberts

SUWANNEE—Shirley L. Hadden

TAYLOR—Walter J. Baker

VOLUSIA—Carroll M. Crouch, C. Robert DeArmas, Alphonsus M. McCarthy, *(Absent—Hugh West)*

WALTON-OKALOOSA-SANTA ROSA — Frederick E. Caldwell, John P. Merchant

WASHINGTON-HOLMES—*(Absent—Walter H. Shehee)*

STATE OFFICERS—Jere W. Annis, James T. Cook Jr., Samuel M. Day, Ralph W. Jack, Walter E. Murphree, Shaler Richardson, William C. Roberts

On motion by Dr. Herschel G. Cole of Hillsborough, seconded by Dr. Clyde O. Anderson of Pinellas, and carried, the minutes of the 1957 Annual Meeting as published in the July 1957 Journal were approved.

On motion by Dr. Walter W. Sackett Jr., of Dade, seconded by Dr. N. Worth Gable, of Pinellas, and carried, the minutes of the called meeting, December 8, 1957, as published in February 1958 Journal, were approved.

President Roberts relinquished the Chair to Dr. Ralph W. Jack, First Vice President.

Dr. Jack: "Tradition through many years has made it customary for your First Vice President to attempt to do something in reality impossible to do. To attempt to introduce to you the man about whom you knew enough to make him your President, I consider impossible. His personal history and past accomplishments for the Florida Medical Association, for medicine in general, and for the community and public medicine are so numerous it took a page and a half of small print in The Journal of the Florida Medical Association in July 1957 to list them all. I will not repeat such now since you are all well familiar with them.

"Since he assumed your Presidency last year and you made me his official stand-in, I have in reality had nothing to do. He has been busy every minute representing you and directing the affairs of the F.M.A. to the greatest benefit of the doctors and the public they serve. He has done a superb job with an abundance of enthusiasm and energy. He has had no need of a 'stand-in.' So, since I cannot introduce one who is already your congenial and good friend, I will break tradition a bit and do one other thing. Instead, I thank you for giving me the honor and privilege of presenting to you a man of many accomplishments, a gatherer of hosts of friends, a graduate of distinction of the universities of two of our great neighboring and sister states, Alabama and Tennessee, a most capable practitioner of both the science and the art of medicine, your President, and, as the great physician, Sir William Osler might allow us to say—'Florida's Alabama student'—Dr. William C. Roberts of Panama City."

As Dr. Roberts stepped to the rostrum, the House of Delegates rose in tribute.

(The complete text of the Presidential Address appears in this issue on page 19).

President Roberts resumed the Chair and asked Dr. Henry L. Harrell, of Marion, to introduce his guest.

Dr. Harrell: "I am sure this group will appreciate a man like Dr. John DeTar, of Michigan, because he gives so much of his energy and talents to organized medicine. He is past president of the National Academy of General Practice. He is a delegate to the A.M.A. from Michigan and Dr. Holland tells me that he has been on Reference Committees with him and how much he is respected in the House of Delegates of the A.M.A. I take great pleasure in introducing Dr. DeTar.

Dr. DeTar: "It is a great honor, I assure you, to be invited to be a guest in this land of oranges, and eternal sunshine. We, in the House of Delegates of the A.M.A., prize highly our acquaintanceship with the delegation from Florida. You should be very proud of the work of your delegates. We have an idea in Michigan somewhat like yours—we think the next President-Elect of the American Medical Association will be a Florida man—in fact, you may count on our support."

Dr. Roberts asked Past President Herbert E. White to introduce the next guest.

Dr. White: "We have in this audience a man who has meant a great deal to Florida medicine. He is here in an official capacity. Last February, the Chairman of the Committee on Legislation and Public Policy, Dr. Phillip Hampton, asked the Governor to appoint a committee to be known as the Governor's Citizens Medical Committee on Health. This committee is composed mainly of physicians, with a representative and a Senator. If you will look on page 33 of your Handbook, you will find out what the function of this committee is. This man, in my opinion, has done more for the medical profession than anybody who has been in Tallahassee since I have been in Florida, and that is thirty-three years. Everything we have asked him to do, he has tried to do.

"It is a great pleasure for me to introduce to you Senator Verle A. Pope of my own county, St. Johns (District 31)."

Senator Pope: "It is indeed a pleasure for me to be here and greet so many doctors. I do think that the last two sessions of the Legislature have been the most successful we have ever had in protecting the public against practices which were obviously to their disadvantage. I want to congratulate the doctors of F.M.A. for the action and cooperation which made that possible. I was called in by the medical society in my own county on this problem and I told them I would attempt to correct these things but that I could not offset the power of those groups unless we could summon the assistance of doctors and thereby be able to put a stop to the practice of medicine by people who had almost no qualifications in that field. I am glad to say that the members of the medical profession responded to that call and realized that not only did they have an obligation to their own profession, but also to the public.

"I have a very high esteem and respect for the medical profession, but want to be fair enough to say that sometimes I do feel that as citizens of this state you, who have the greatest opportunity, have not always given to us in the field of state service, all that you could have given in the way of cooperation, assistance and advice. I don't know whether you realize it or not, but you are unquestionably the most influential group of citizens in this state and country. You have a great and deep knowledge of the problems, because among your patients you deal with all classes of people, the low income, average, and people who have great wealth. Certainly there is no group of citizens who are in better position to understand the problems of his fellow men than those in medicine. We have a lot of problems in this state because we are so fast growing. We have done a tremendous amount in the field of education and in the field of public health, but there is so much more to be done. Your services will be needed so much in the future.

"I would like to pause long enough to congratulate your Director of Public Relations, Mr. Parham, and to congratulate Dr. Hampton for the splendid advice he has been able to give on legislation. At that last session, he was able to give us a program that saved this state millions of dollars and at the same time enable us to serve the needs of our fellow citizens.

"I am somewhat confused by the tendency of so many people to say that the solution to the problem lies in state or federal authority. When we have a problem that can be solved within a community and it is transferred to Tallahassee, it is indeed a mistake and when it is transferred to Washington, it is a catastrophe."

Dr. Roberts introduced officers of the Woman's

Auxiliary, Mrs. Perry D. Melvin, President and Mrs. Lee Rogers Jr., President-Elect.

A letter from Governor Collins was read by the President, as follows:

Dear Dr. Roberts:

Thanks so much for your letter of April 15, inviting me to attend the Eighty-Fourth Annual Meeting of the Florida Medical Association, in the American Hotel, Bal Harbour, on May 10-14.

I appreciate your thinking of me, and wish that I could be with you, but I will be so terribly involved in the last minute preparations for the National Governors' Conference which will be held at the Americana a few days after your meeting, that it will be impossible for me to be with you, much as I would like to do so.

I trust you will explain to all in attendance my inability to adjust my schedule. Please, also, convey to them my warm personal and official greetings, and extend my best wishes for a successful convention.

With deep appreciation and best personal regards, I am

Sincerely,
LeRoy Collins
Governor

Dr. Roberts introduced Mr. Joe Grotegut, Administrative Assistant to the Governor.

Dr. Homer L. Pearson Jr., Secretary, State Board of Medical Examiners, presented his annual report which was referred to Reference Committee No. 1. He also read a resolution regarding nomination of Dr. Orr as President-Elect of the A.M.A., which was referred to Reference Committee No. 3.

Dr. John D. Milton, Chairman, Medicare Mediation Committee, read his report which was referred to Committee No. 3.

Mr. Elton G. Goldfield, Representative to Student A.M.A. Convention, read a report which was referred to Committee No. 1.

Dr. Roberts asked for nominations for two delegates and two alternates to the American Medical Association for two year terms beginning January 1, 1959.

Dr. Burns A. Dobbins Jr., of Broward, nominated Dr. Reuben B. Chrisman Jr.

Seconded by Dr. Donald F. Marion.

Dr. S. Carnes Harvard moved that nominations be closed and the secretary be instructed to cast a ballot for Dr. Chrisman.

Seconded by Dr. Rowlett.

Motion carried.

Dr. W. Tracy Haverfield of Miami: "I would like to nominate the incumbents for reelection, Dr. Holland as Delegate and Dr. Gray as alternate for Dr. Chrisman, Dr. Murphree as alternate for Dr. Holland."

Seconded by Dr. Milton,

Dr. Joseph W. Douglas, of Escambia, moved that nominations be closed.

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Dr. Roberts read the personnel of the five reference committees as follows:

1. HEALTH AND EDUCATION
Floridian Foyer
C. Frank Chunn, *Chairman*
Walter E. Murphree
Walter J. Glenn Jr.
Kenneth A. Morris
Paul F. Baranco

2. PUBLIC POLICY
Eastward Room
Robert F. Dickey, *Chairman*
Leo M. Wachtel
Robert L. Tolle
Norval M. Marr Sr.
Marion W. Hester

3. FINANCE AND ADMINISTRATION
Barbados Room
Herbert E. White, *Chairman*
Edward W. Cullipher
Egbert V. Anderson
H. Phillip Hampton
Donald F. Marion

4. LEGISLATION AND MISCELLANEOUS
Bermuda Room
L. Washington Dowlen, *Chairman*
Burns A. Dobbins Jr.
Joseph J. Lowenthal
Millard P. Quillian
Edward R. Annis

5. BLUE SHIELD
Westward Room
Thomas C. Kenaston, *Chairman*
S. Carnes Harvard
W. Dean Steward
Ernest R. Bourkard
Wm. F. Humphreys Jr.

The following committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented:

(To Reference Committee No. 1)

Scientific Work, George T. Harrell Jr.
Medical Postgraduate Course, Turner Z. Cason
*Cancer Control, Ashbel C. Williams
Venereal Disease Control, C. W. Shackelford
Tuberculosis and Public Health, Lorenzo L. Parks
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
Report of Secretary, State Board of Medical Examiners, Homer L. Pearson Jr.
Report: Representative to Student A.M.A. Convention

(To Reference Committee No. 2)

Conservation of Vision, Carl S. McLemore
*Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Robert E. Zellner
*Representatives to Industrial Council, Pascal G. Batson Jr.
Grievance, Frederick K. Herpel
*Nursing, Thomas C. Kenaston
*Blood, James N. Patterson

(To Reference Committee No. 3)

Address of President, William C. Roberts
*Board of Governors, William C. Roberts

*Necrology, J. Basil Hall
Advisory to Woman's Auxiliary, Merritt R. Clements
*Councilor Districts and Council, S. Carnes Harvard
Advisory to Selective Service for Physicians and Allied Specialist, J. Rocher Chappell
Civil Defense and Disaster, J. Rocher Chappell
Resolution: Discontinuance of District Meetings
Report on Medicare, John D. Milton

(To Reference Committee No. 4)
*Legislation and Public Policy, H. Phillip Hampton
Mental Health, Sullivan G. Bedell
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.
Resolution: BB Guns To Be Declared Illegal
Resolution: Forand Bill

(To Reference Committee No. 5)
*Advisory to Blue Shield, Henry J. Babers Jr.
Resolution: Blue Shield Board of Directors

*Supplemental report presented and referred.

When Dr. Henry J. Babers Jr. presented his supplemental report, Dr. Douglas moved that it not be read, since it had been mailed to all delegates in advance. This motion was duly seconded and carried.

President Roberts asked for additional resolutions from the floor.

Dr. Carl S. McLemore requested the privilege of the floor for Dr. Benjamin Glaser, who presented another resolution on BB guns, similar to the one presented in the Handbook, except that this one had been approved by the Florida Society of Ophthalmology and Otolaryngology. This was referred to Committee No. 4.

Dr. Herbert L. Bryans, of Escambia, presented a resolution on replacing interns within limitation of existing law. This was referred to Committee No. 4.

Dr. Marion W. Hester, of Polk, presented two resolutions, one dealing with Optometry, and the other on Professional Liability Insurance. Both resolutions were referred to Committee No. 4.

Dr. Walter C. Jones, of Miami, presented a resolution on hotels for the annual meeting which was referred to Committee No. 3.

Dr. Robert P. Keiser, of Dade, presented a resolution on use of experimental animals which was referred to Committee No. 4. Also, a resolution on compulsory immunization of school children which was referred to Committee No. 4, a resolution on Blue Shield income limit, and one on out-patient services, which were referred to Committee No. 5, and a resolution on surgical assistants compensation under Blue Shield which was referred to Committee No. 5.

Dr. Burns A. Dobbins Jr., of Broward, presented resolutions approving the $6,000 income limit for Blue Shield and one recommending special commendation for Dr. Babers and the Committee of Seventeen, which were referred to Committee No. 5. He also presented a resolution on the location of called meetings of the House of Delegates, which was referred to Committee No. 3.

Dr. Roberts announced that the portion of the supplemental report of the Board of Governors dealing with the Forand Bill and the recommendation of the Board of Governors to sponsor legislation to amend the Florida statutes to permit group insurance coverage for members of associations, would be referred to Committee No. 4.

Dr. Haverfield announced that arrangements are being made for a chartered airplane for transportation to the AMA meeting in San Francisco and that interested members should get in touch with him.

Dr. Walter E. Murphree announced that the teaching hospital at the University of Florida will open the middle of October. The policies recommended by the Medical Schools Liaison Committee will be followed in the operation of this hospital; patients will be referred by practicing physicians and all patients will be used for teaching purposes. Also to be announced is that the University of Florida Teaching Hospital will cooperate with the indigent hospitalization program. Details of this announcement will be mailed in the very near future to the secretaries of the various county medical societies and also, a little later, they will be mailed to each member of the association.

The President announced a meeting of the Florida Committee for Better Government and the Secretary urged all physicians to avail themselves of the opportunity for a free physical examination.

The House of Delegates recessed at 6:30 p.m. to reconvene at 9:30 on Wednesday, May 14, 1958.

SECOND HOUSE OF DELEGATES

The House of Delegates reconvened at 9:30 a.m. on Wednesday, May 14, 1958, in the Bal Masque Room of the Americana Hotel, Bal Harbour, President William C. Roberts, presiding.

Dr. Louis M. Orr, Chairman of the Credentials Committee, reported 156 out of a total of 171 delegates present and seated.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, G. Leonard Emmel
BAY—Wm. F. Humphreys Jr.
BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston
BROWARD—Norris M. Beasley, Julius F. Boettner, Russell B. Carson, Burns A. Dobbins Jr., Richard L. Foster, *(Absent—Anthony C. Galluccio, Walter J. Glenn Jr.)*, John H. Mickley, Richard A. Mills
COLLIER—Daniel B. Langley
COLUMBIA—Laurie J. Arnold Jr.
DADE—Edward R. Annis, Morris H. Blau, John E. Burch, Chester Cassel, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Frederick E. Farrer, Richard M. Fleming M. Eugene Flipse, J. Raymond Graves, Maurice M. Greenfield, W. Tracy Haverfield, Claude D. Holmes Jr., James J. Hutson, Christian Keedy, Robert P. Keiser, David Kirsch, Alfred G. Levin, Donald F. Marion, John D. Milton, Harold Rand, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Chauncey M. Stone Jr., Wm. M. Straight, Arthur W. Wood Jr., Jack L. Wright, Nelson Zivitz *(Absent—Edwin P. Preston, Clifford C. Snyder)*
DESOTO-HARDEE-HIGHLANDS-GLADES — Gordon H. McSwain
DUVAL—Frederick H. Bowen, Hugh A. Carithers, J. K. David Jr., Lawrence E. Geeslin, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Edward Jelks, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, C. Burling Roesch, John T. Stage, Sidney Stillman, Leo M. Wachtel, Ashbel C. Williams
ESCAMBIA—Egbert V. Anderson, Pascal G. Batson Jr., Herbert L. Bryans, Joseph W. Douglas, Sidney G. Kennedy Jr. *(Absent—Paul F. Baranco)*
FRANKLIN-GULF—John W. Hendrix
HILLSBOROUGH—Samuel H. Adams, Collin F. Baker Jr., Ernest R. Bourkard, C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., James N. Patterson, Wesley W. Wilson *(Absent—Wm. M. Rowlett)*
INDIAN RIVER—Erasmus B. Hardee
JACKSON-CALHOUN—Grayson C. Snyder
LAKE—Fred A. Vincenti
LEE-CHARLOTTE-HENDRY—H. Quillian Jones, John S. Stewart
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Francis T. Holland, George H. Massey, Robert H. Mickler, George S. Palmer
MADISON—*(Absent—A. Franklin Harrison)*
MANATEE—Millard P. Quillian, Willett E. Wentzel
MARION—Henry L. Harrell, Eugene G. Peek Jr.
MONROE—Ralph Herz
NASSAU—*(Absent—Benjamin F. Dickens)*
ORANGE—Chas. J. Collins, Duncan T. McEwan, Carl S. McLemore, Fred Mathers, Louis M. Orr, Frank J. Pyle, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert L. Tolle, Robert E. Zellner
PALM BEACH—Willard F. Ande, Charles McD. Harris Jr., Lorenzo James, *(Absent—V. Marklin Johnson)*, Ralph M. Overstreet Jr., W. Lawson Shackelford, Younger A. Staton, *(Absent—A. Scott Turk)*
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, Elmer B. Campbell Sr., Raymond H. Center, N. Worth Gable, Francis H. Langley, Jack A. MaCris, Norval M. Marr Sr., J. Braden Quicksall, Robert T. Walker, Walter H. Winchester, Rowland E. Wood *(Absent—Arnold S. Anderson, Orville N. Nelson)*
POLK—James R. Boulware Jr., Marion W. Hester, Coy L. Lay, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr.
PUTNAM—Grover C. Collins
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott
SARASOTA—John M. Butcher, Karl R. Rolls, Melvin M. Simmons
SEMINOLE—Wm. V. Roberts
SUWANNEE—*(Absent—Shirley L. Hadden)*
TAYLOR—Walter J. Baker
VOLUSIA—Carroll M. Crouch, C. Robert DeArmas, Alphonsus M. McCarthy, *(Absent—Hugh West)*
WALTON-OKALOOSA-SANTA ROSA—Frederic E. Caldwell, John P. Merchant
WASHINGTON-HOLMES—*(Absent—Walter H. Shehee)*
STATE OFFICERS—Jere W. Annis, James T. Cook Jr., Samuel M. Day, Ralph W. Jack, Walter E. Murphree, Shaler Richardson, William C. Roberts

Dr. Roberts: "We have some very distinguished people here, and I want to call on a man who represents a very fine organization, a very influential organization, and one with whom we claim kinship. I would like to ask the President of the Florida Bar, Mr. Baya M. Harrison Jr., to come forward."

Mr. Harrison: "Dr. Roberts, Members of the House of Delegates, Members of the Florida Medical Association:

"This is a somewhat unusual opportunity that I have to make a second appearance before this distinguished gathering. I was afforded that fine occasion last year and the circumstances of the dates of our meetings so coincide that I have that privilege again. I am most grateful for it. I asked one of your members whether there was anything I should say and he asked whether I, too, was president of a state organization. I admitted I was and he said that perhaps this group would appreciate brevity.

"You will recall also that last year I spoke of the desire of the Florida Bar to cooperate in every instance with the Florida Medical Association, both on a state and through our voluntary associations on a local level, and promised a liaison which I hoped would be effective. Just to show the extent to which the Florida Bar will go to achieve an end, we have elected as President-Elect, and he will assume the presidency of the Florida Bar on Saturday, a member of a very

distinguished professional family which is very close to the Florida Medical Association. His father was a former president, the late Dr. John S. McEwan, his uncle, Dr. Jack Edwards, also served as your president, his cousin, Dr. Duncan McEwan, was only recently your president. I have reference to the incoming president of The Florida Bar, The Honorable O. B. McEwan of Orlando.

"Gentlemen, under those circumstances, if a very close and abiding liaison cannot be maintained between our two wonderful professions, I have nothing further to offer or suggest.

"We are, of course, delighted to follow you at this marvelous hotel; this is our second year here. We enjoyed it so much last year that we are coming again. We do not begrudge your having been here first; the members of the legal profession are quite used to taking the left-overs from you distinguished gentlemen.

"In any event, I do wish to say for the 7,500 lawyers and judges in this state, how much we appreciate the important part the medical profession plays, not only in Florida but throughout the country. We who are so vitally interested in the proper administration of justice realize more every day how much the medical profession means to the proper administration of justice. We are anxious to continue the liaison to which I referred and we know in the future it is going to continue to prosper and grow.

"Again, it is a great pleasure to be with you."

Dr. Roberts introduced Dr. Walter W. Sackett Jr., Acting Chairman of the Necrology Committee.

Dr. Sackett: "Gentlemen, we opened our Sunday session with a very nice prayer presented by our own Dr. Homer Pearson. It is only fitting this morning that we open this meeting likewise, however, for this particular moment of reverence, we have a specific purpose and that is to honor and offer reverence to those forty-two of our members who have departed since our last meeting. Many of these men probably were with us last year. For this purpose, we have asked Dr. Joseph R. Narot. Rabbi Narot is well known in this locality; he is president of the Rabbinical Association, and is the Rabbi of Temple Israel of Greater Miami.

Rabbi Narot: "You have set aside a period for reflection on the lives of those of your colleagues who have passed away. Permit me to say that it is good that you should do so. Not that any among you needs to be reminded of the reality of death. Each of you confronts that reality in an immediacy of involvement from which the layman, medically speaking, is spared. But this very immediacy of involvement must call for a detachment that will reduce the jeopardy to your professional effectiveness. And this detachment could conceivably give way to a cynicism that would mar your reverence for the miracle of life and to a callousness that would disturb the awe in which we must all stand before the mystery of death.

"Nor do I mean that it is quite enough occasionally to contribute a fleeting and pious thought to nameless men whom we may not have known personally in their lifetime, some of whom, indeed, in our natural state of humanity, we may have even once regarded critically, competitively or indifferently. Rather must such a moment as this summon us to relate the meaning of their death to the significance of our lives. For as Khalil Gibran has written in his unique lyrical and haunting genius of expression: 'You would know the secret of death. But how shall you find it unless you seek it in the heart of life? For life and death are one, even as the river and the sea are one.'

"The oneness of life and death in one sense, that is to say, in the undeniable fact that what is born must also in its earthly nature die, has been noted, of course, by every civilization. The ancient Greeks, for example, composed a legend of three fateful sisters on Mt. Olympus. Clotho, they said, spins the web of life. Lachesis measures its length. While Atropos waits with shears in hand to cut the thread when the appointed time comes. Thus did Greek culture of antiquity bespeak its characteristic perception for tragedy. But man must not only die; he must also live. And man cannot live by tragedy alone.

"For this reason man has searched his heart and mind for a faith that will blunt the impact of the tragedy which threatens to overwhelm him. To resist the agonizing, unendurable thought of oblivion, man has wished for eternal life. Freud called that mental process an illusion; but, as he himself observed, to say that something is ardently wished for does not prove or disprove the existence of the object of that wish. Only faith, in the heart of each of us, strengthened by his spiritual heritage, can prove for each of us the extent to which he can defy death and achieve immortality.

"Thus, there are those of us who find solace in the belief that man dies, only to be born anew. The vocabulary varies somewhat with differing religions. For the Christian it is heaven that beckons; for the Jew it is the life of the world to come that awaits him. But the thought is essentially the same and the conditions for man proving himself worthy of that after-life are the same; a life lived to the greatest extent possible in goodness, in integrity, in service to others.

"Then there are those—and they, too, are to be found in every denomination—who say that their limited understanding does not permit them to put credence in literal personal immortality. Instead, they see man as created of perishable body and immortal soul. 'The dust returns unto the earth as it was, but the spirit unto God who gave it.' To this conviction many a Jew and Christian assents in comforting alleviation of the tragic. And these men, moreover, feel instinctively that we have a responsibility, while we live, to treasure that breath of God, that life, however frail, tenuous and brief it may be, within us and within our fellowmen. To treasure it, to respect it, not to abuse, oppress or exploit it, to believe in it because it stems from the one life-giving Creator of all existence, this is our responsibility. 'Life is a dialogue between God and man,' the contemporary scholar Martin Buber has suggested, 'God speaks to us by giving us life, and we answer through the kind of life we live.' It was this kind of faith, too, we may be sure, that prompted a rabbi of old to declare—with obvious especial appreciation for you who are gathered here—'He who helps to heal one life, it is accounted to him as though he has created an entire universe.'

"Finally, there are those, and they likewise are to be found among men of every religious origin, who say that for them the tragedy of life is adequately

softened, not by any speculation concerning personal immortality—be it through the total person or the soul alone—but by the contemplation of the continuity of society. 'When a righteous man dies, he dies only to his own generation,' an ancient Hebrew sage declared, 'it is with him as with a man who loses a pearl. It remains a pearl and is lost only to its owner.' Yes, the individual dies, but the purposes he serves in his lifetime live on. Righteousness is his immortality, the pearl he may lose but which mankind will keep and cherish.

"The conclusion seems to be inescapable: we may have several views of death; there can be only one purpose to life. When we stop, therefore, in reverent reminiscence of those who have gone on before us, let us pray that their faith in death has been vindicated, even as their service to life is remembered. And as we remembered them, let us pray that *we,* too, may find it possible to think of the oneness of life and death. Let us strive to soften our angers, sweeten our bitternesses, lessen our envies, and replace them all gradually with greater compassion and more understanding. Let us rise and think of the valiant dead. Let us think of them each to himself, each of us in his own vocabulary of faith. Let our lips be silent as our hearts would speak. . . . May the words of our mouths and the meditations of our hearts be acceptable before Thee, O Lord, our Rock and our Redeemer.

Amen."

Dr. Roberts: "Before we go on with our agenda, I want to call to your attention two of the members of the Florida Medical Association who have distinguished themselves and should be recognized. Dr. Chas. J. Collins, of Orlando, is the President of the South Atlantic Association of Obstetricians and Gynecologists.

"We also have another outstanding member, Dr. Ralph Sappenfield, of Miami, who is President of the American Society of Anesthesiologists."

"I will now turn the meeting over to our Secretary, Dr. Sam Day."

Dr. Day: "It is said that life begins at 40. Florida Medical-wise, these gentlemen are hardly qualified yet, but they have contributed their part in our organization in their 35 years of service. We come now to the awarding of life membership certificates."

Dr. Day read the roll of Life Members and presented certificates to those in attendance.

Dr. Roberts: "I would like to advise the members of the House of Delegates that we have at this session a parliamentarian, Dr. Franklin Evans, who will serve in this capacity. He will advise the President and will advise the Chair. Dr. Evans, please stand. His advice is also available to any of you and we are grateful to him for serving. I think Dr. Evans deserves a little extra credit, because he is both an attorney and a doctor of medicine."

"We will now have the reports of the Reference Committees. Will Dr. C. Frank Chunn please make his report."

Report of Reference Committee No. 1

Dr. Chunn: "Mr. President and Members of the House of Delegates:

"Your reference committee gave careful consideration to items referred to it and makes the following report:

"The Report of the Committee on Scientific Work is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Holland.

Motion carried.

Report of Committee on Scientific Work

GEORGE T. HARRELL JR., *Chairman*

The program for the 1958 Annual Meeting follows the reorganization first used in 1957. The favorable comment from that session encouraged the Committee to continue the grouping of scientific papers by Florida physicians into two sessions on a single day, so that the House of Delegates and Reference Committees might meet without conflict with other activities.

The Committee met Nov. 16, 1957, in Gainesville to review the abstracts of papers, exhibits, and movies proposed for the program of the 1958 Annual Meeting. The number of applications for a place on the program was gratifying. The promptness of members of the Association in suggesting titles for papers made this portion of the work of the Committee easier this year.

Since a larger exhibit hall is available this year than last, the number of scientific exhibits has been increased considerably. The greater flexibility in size of space for individual exhibits provided this year has been helpful in the selection of exhibits and should be continued. It was not possible to arrange a nationally televised medical program this year. Though the Kinescopes of previously televised programs, shown as part of the program of Scientific Movies at the 1957 Meeting, was excellently received, the number of new scientific movies proposed by Florida physician for the 1958 program was disappointingly small. Accordingly, movies were not scheduled this year, but it is recommended that this feature receive further emphasis in future years.

It is strongly recommended that the members of the Association plan as early as a year in advance for their exhibits and movies so that titles and abstracts can be submitted in the fall. The complete program can be selected, authors and exhibitors can be notified by the middle of January, and the program can be printed in The Journal on time.

The Committee recommends the continuation of the appropriation of $250 per year to permit the invitation of distinguished out-of-state guests for participation on panels, symposia and the scientific portion of the general session program.

Dr. Chunn: "The Report of the Committee on Medical Postgraduate Course—in connection with this report, the Reference Committee moves the adoption of this report and also recommends to the House of Delegates that this committee be maintained in an advisory capacity. We would like to again commend Dr. Turner Z. Cason for his 27 years of service as Chairman of the Committee on Medical Postgraduate Course.

"I move the adoption of this portion of the report as amended."

Seconded by Dr. Rowland E. Wood.

Motion carried.

Report of Committee on Medical Postgraduate Course

TURNER Z. CASON, *Chairman*

The Committee on Medical Postgraduate Course met in Jacksonville on February 24, 1957, following the Seminar on Cardiovascular Diseases. Plans were discussed for expansion of the cardiovascular program next year and recommendations made for presentation to the local heart association. Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Florida, pledged continued cooperation of the school's Division of Postgraduate Education in promoting this program.

Progress in planning for the 25th Annual Graduate Short Course, scheduled for June 24-28, was reported. Since the Short Course was to be held in Gainesville and was to be the first such postgraduate course presented at the College of Medicine, it was suggested that Dr. Harrell and his staff present the five special lectures, and his recommendation of Laboratory Diagnostic Methods for the subject of the lectures was approved.

Hematology was again chosen as the subject for the Special Course, planned for June 20-22, immediately preceding the Short Course. This course also was scheduled to be held at the College of Medicine in Gainesville, and Dr. Harrell offered the services of the College in preparing for any demonstrations desired.

In keeping with the Committee's efforts to avoid conflicting dates and duplication of seminars and otherwise promote cooperation between all organizations presenting medical postgraduate education, an exhibit was approved for the annual meeting of the Florida Medical Association in May. This exhibit, later built by the Medical Illustrations Department of the College of Medicine, consisted of three panels depicting postgraduate educational courses, according to specialty, scheduled in Florida and also in the nation as a whole. On display at the Association's 1957 meeting, this unique presentation attracted wide attention and served its purpose well.

The year 1957 marked the inclusion of the Division of Postgraduate Education as an integral part of the College of Medicine of the University of Florida with future courses and seminars emanating from that source. In view of this impending change, the Committee took action at its February meeting to insure direction of remaining funds for purposes of medical postgraduate education only. The proposal by Dr. William D. Cawthon that the money be placed in a fund designated as the Medical Postgraduate Fund and earmarked for this use only was favorably received by Dean Harrell, who agreed to investigate setting up such a fund. The Committee then unanimously approved the transfer of funds remaining in the account of the Director, Department of Medicine, Graduate School, University of Florida, in the Atlantic National Bank of Jacksonville, to a special account, to be arranged for by the University, with the understanding that the use of these funds would be for the purpose of medical postgraduate education.

The following courses were presented during the year:

Seminar on Cardiovascular Diseases, Jacksonville, February 21-23, 1957, with 105 in attendance.

Seminar on Hematology, Gainesville, June 20-22, 1957, with 56 attending.

25th Annual Graduate Short Course, Gainesville, June 24-28, 1957, with 84 registering.

Seminar on Diabetes Mellitus, Gainesville, October 24-26, 1957, with 46 in attendance.

12th Annual Midwinter Seminar on Ophthalmology and Otolaryngology, Miami Beach, January 27-February 1, 1958, with 440 attending.

On July 1, 1957, Dr. William C. Thomas Jr., of Gainesville, assumed the duties of Director of the Division of Postgraduate Education of the College of Medicine of the University of Florida. The cause of medical postgraduate education in Florida is assured and its future bright with such leadership as Dr. Thomas and Dean Harrell will provide under the auspices and with the resources of a great state university. The Association's Committee on Medical Postgraduate Course now envisions its future role as advisory in character and is pleased to cooperate in every way possible to promote medical postgraduate education in this auspicious setting and also to be at the service of other institutions and organizations throughout the state which are active in this field.

Dr. Chunn: "The Report of the Committee on Cancer Control as printed in the Handbook is approved.

"The committee recommends disapproval of the resolution as submitted to the First House of Delegates. The committee felt the possible disturbance of physician-patient relationship and that competent hospitals and staffs may be eliminated from the program. We, therefore, proposed further investigation and study of the program by interested groups.

"Mr. President, I move the approval of the action of the committee.

Seconded by Dr. Murphey.

The Chair recognized Dr. Ashbel C. Williams of Jacksonville.

Dr. Williams: "I would like to request, if possible, to have the resolution read to the House of Delegates if that is in order."

Dr. Chunn read the resolution.

Dr. Williams: "This resolution was the result of a year's very thorough study of this problem. There has been a steady decline in most of our tumor clinics' volume during this year, at a time when because of increased population and financial difficulties, you would logically expect it to be going up instead of down.

"These 19 clinics are teaching centers for cancer for the physicians in this state and for the residents and interns. We, on the Cancer Committee, believe that it is essential to continue the upward level of cancer training in both these categories to keep these cancer clinics intact with the present fine goals and if we have no restrictions whatsoever on the handling of cancer patients, the clinics are going to die on the vine. If you want to see the cancer handling in this

state put on a higher standard, I strongly recommend that you approve the resolution as amended.

"This is no departure. Up until the first of last July, we operated under an arrangement whereby the Board of Health would not pay for cancer patients unless they went to one of these facilities. We do not need a new law. All we need is to recommend to the Board of Health that they again do what they did until the first of last July and it will solve most of the inequities.

"I offer a substitute motion that this resolution be approved as it was amended by the reference committee and approved at the first meeting of the reference committee."

Seconded by Dr. Sias.

Drs. H. Phillip Hampton, of Hillsborough, and Edward R. Annis, of Dade, spoke against the resolution.

Drs. Charles McD. Harris Jr., of Palm Beach, and Miles W. Thomley, of Orange, spoke in favor of the resolution.

The Chairman asked for a standing vote on the substitute motion.

Substitute motion carried.

Dr. Chunn: "Mr. President, going back to the report of the Cancer Control Committee as printed in the Handbook. I move that this portion of the report be approved."

Seconded by Dr. Harris.

Motion carried.

Report of Committee on Cancer Control

ASHBEL C. WILLIAMS, *Chairman*

This Committee, along with the Florida Cancer Council, has for the past two years encouraged the development of cytodiagnosis in Florida. The American Cancer Society, Florida Division, was authorized to establish scholarships for pathologists wishing refresher courses in cytology and for technician trainees in cytological training. The Cancer Society was encouraged to subsidize the setting up of community cytological facilities where feasible. Several pathologists and a number of technician screeners have availed themselves of the above scholarships. A pamphlet entitled "Manual of Exfoliative Cytology," formulated by the Florida Society of Pathologists, has been made available to the physicians of the state. A pamphlet, "What Every Woman should know about the Cell Examination for Uterine Cancer," has also been prepared for lay consumption and is in circulation. These pamphlets were both financed by the American Cancer Society, Florida Division. The cytological program in Florida is improving and spreading at a gratifying rate.

Representatives of the Cancer Control Committee met with the Florida Cancer Council and the Tumor Clinic Directors of Florida in Jacksonville, Oct. 18, 1957. This meeting was called to ascertain what effect the new state law for the emergency care of the indigent is having on the care of the cancer indigent and the Tumor Clinics. Fears were expressed that this law would lead to lowering of standards of treatment because of patients being diverted from the Tumor Clinics where they were formerly required to be sent for treatment. The new law allows them to be treated in any recognized hospital facility in Florida. A resolution was passed to the effect that the Florida State Board of Health be asked to request of the counties that all indigent cancer patients requiring hospitalization or special treatment be handled through one of the nineteen Tumor Clinics set up for this purpose.

Another meeting on the above subject is planned for early March, 1958. If information develops which indicates a further deterioration in the cancer indigent care, appropriate suggestions will be made by this Committee and the Florida Cancer Council to the Florida State Board of Health and the House of Delegates of the Florida Medical Association.

Supplement

Whereas, a Survey of the 19 tumor clinics in Florida has shown a significant decrease both in new patients and in patient visits since cancer came under the Hospital Service for the Indigent Program eight months ago and,

Whereas, one of the great advantages of our tumor clinics has been their educational value both in the training of the visiting physicians and hospital residents and interns, which educational value has been decreased and jeopardized by the fall off in patient volume in the clinics and,

Whereas, certain tumor clinics because of local county conditions are unable to obtain payment for cancer indigent patients under the Hospital Service for the Indigent Program which has resulted in a diversion of patients from these clinics and,

Whereas, since cancer patients may be treated in any recognized hospital in Florida under the Hospital Service for the Indigent Program this has resulted in many such patients being treated in small hospitals lacking pathological and radiological facilities as well as other supporting specialists often necessary to the proper management of cancer problems which standard of patient care is not comparable to that offered in our organized tumor clinics and,

Whereas, since the cost to the Florida State Board of Health and to the American Cancer Society and to the various hospitals housing tumor clinics, of maintaining the tumor clinics, remains about the same though fewer patients are being seen and treated, therefore we are not realizing the maximum value from our cancer dollars used to operate the tumor clinics.

Therefore, be it resolved by the Florida Cancer Council and the Cancer Control Committee of the Florida Medical Association assembled in joint meeting March 1, 1958 at Jacksonville, Florida that:

The State Board of Health be urged to put into effect the policy that except in cases of an acute emergency, all cancer patients be channeled for diagnosis and management to one of the approved tumor clinics as a prerequisite to state assistance under the Hospital Service for the Indigent program, that

A copy of this resolution be forwarded to the Florida State Board of Health.

Ashbel C. Williams, M.D.
President, Florida Cancer Council
Chairman, Cancer Control Committee

Dr. Chunn: "The Report of the Committee on Venereal Disease Control is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Carl S. McLemore, of Orange.

Motion carried.

Report of Committee on Venereal Disease Control

C. W. SHACKELFORD, *Chairman*

Since the treatment and cure of primary venereal diseases are so easy and economical, it behooves every physician to use more vigilance in finding the cases.

Patients should feel that they have had a poor check-up unless a blood test for syphilis has been given. When indicated Treponema Pallidum and Gram negative intracellular diplococci should be looked for and when found positive, adequate treatment should be instituted promptly. The indigents may be sent to the County Health Department for treatment and disposition.

By all means, every infectious case should be reported to the health department. They are anxious and willing to send a trained V. D. interviewer-investigator to find contacts or render other services for which he is trained.

Your Committee learned through the State Board of Health that private physicians reporting has resulted in approximately one half of the syphilis morbidity. Well and good, but we could do better.

We commend the Venereal Disease Control Division of the Florida State Board of Health for doing a conscientious job. They are continually carrying on a campaign of education among the general population. They respond to every request from private physicians for whatever aid they feel is needed.

It is discouraging to learn that in certain sections of the state the incidence of primary and secondary syphilis cases has not been reduced in the past year.

Your committee chairman is in active general practice in Panama City in northwest Florida and he has not seen a primary or secondary case of syphilis in more than a year out of 296 tests by the State Health Department Laboratory. There have been no cases of chancroid, granuloma inguinal or lymph granuloma venereum and only six cases of gonorrhea.

It is my personal opinion that the obliteration of the scourge of venereal disease depends upon the vigilance of private practicing physicians examining, diagnosing, reporting and treating the cases found.

All the necessary facilities are available through the Florida State Board of Health.

Now, lets work harder to improve the venereal situation in all our state.

Dr. Chunn: "The report of the Committee on Tuberculosis and Public Health is approved as published in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Clyde O. Anderson.

Motion carried.

Report of Committee on Tuberculosis and Public Health

LORENZO L. PARKS, *Chairman*

The Committee had no meetings during the year, but several matters were handled by mail or by direct contact with members. The major activity was to consider and recommend approval of the idea that facilities be set up at the next annual meeting whereby each physician in attendance would be offered an electrocardiogram, chest x-ray, and certain laboratory tests. Many of us are too busy at home to think of these things for ourselves.

A similar project has been successful at the American Medical Association annual meetings in the past few years and it was believed that it should be offered at our Annual Meeting. Approval was obtained for this project from the President and the Board of Governors. It is hoped that each physician will take advantage of this opportunity while attending the meeting, in the interest of his own health. The Woman's Auxiliary has been asked to assist in this project, as well as the two medical schools, State Board of Health, and the Dade County Medical Association and certain physicians of the state.

In November there was a press release pertaining to the dangers of mass chest x-ray. A request was made that our Committee study this matter. After reading the complete release of the U. S. Public Health Service—only a small portion of which was quoted in the press—it was clear that the U.S. Public Health Service favored continuation and extension of chest x-ray surveys of all population groups in which the number of cases of disease found justified the use of this method. It was also observed from this statement that the U. S. Public Health Service does not feel there is any significant risk to people so examined.

Our Committee reviewed the recommendations and correspondence between Dr. Roberts Davies, Director of the Tuberculosis Board, and Dr. Clarence M. Sharp, Director, Division of Tuberculosis Control, Florida State Board of Health. After reviewing much material pertaining to this subject, it is recommended that the following be used as the guiding principles that unify the policy as it bears upon tuberculosis x-ray case finding activities:

1. Mass radiography of the chest, operated under competent auspices, is a fundamental technic in the detection of tuberculosis.
2. Mass x-ray casefinding should be applied selectively in groups at high risk of tuberculosis infection and disease.
3. All tuberculosis x-ray survey programs should have the prior approval of the applicable state or local health department.
4. Consideration should be given to the tuberculin test as an initial screening device in low prevalence groups.
5. Every community should evaluate on a continuing basis its tuberculosis problem, needs and resources, so that local x-ray surveys may have efficient use and maximum effect.
6. Adequate safeguards should be utilized to protect all persons from unnecessary radiation.

Our attention has been called to the need for reporting tuberculosis cases. Now that many cases no longer require institutional care, the number reported has dropped some, perhaps more than is actually the case. In order to continue to measure the progress in the control of this disease, physicians are urged to report to the health departments all cases of tuberculosis under their care, and especially if under home care.

The question of diabetes screening tests by health departments for the detection of early diabetes was brought to the attention of the Committee. This question was presented to the House of Delegates in June, 1950, and approved by the Association at that time. Therefore, no further action is recommended on this subject at this time.

Florida leads the nation in reported tetanus both for mortality and morbidity, and the rates among the nonwhites are the highest in the nation. Surveys for tetanus immunization levels in Florida have shown low levels of protection except in school age children. It is well known that tetanus cases and deaths are potentially preventable with active immunization.

It is recommended that active tetanus immunizations be given to all citizens of Florida at all ages. It is further recommended that an intensive program of immunization be made to prenatal cases, especially those that are to be delivered by midwives; and also patients with chronic skin ulcerations.

Your Committee recommends that each county medical society, in conjunction with its County Health Department, conduct an educational program as well as an immunization program to lower the tetanus morbidity and mortality rates in Florida.

Dr. Chunn: "The Report of the Committee on Maternal Welfare is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Fred Mathers.

Motion carried.

Report of Committee on Maternal Welfare

E. FRANK McCALL, *Chairman*

The Maternal Welfare Committee has had two planned meetings for discussion; one at the Forida Medical Association meeting and one at the meeting in Daytona Beach. The Maternal Welfare Committees sponsored by the State Boards of Health of Florida, Georgia, South Carolina, and Alabama held an Obstetric and Pediatric Seminar at Daytona Beach, September 9-11. Alabama came into our group in 1957, making it a four state group. The registration was 401 which is the largest meeting we have ever had. The faculty for this meeting was as follows:

Dr. Virginia Apgar, Columbia University
Miss Maude C. Bailey, R.N., Director of Public Health Nursing, Charleston, S. C.
Dr. Jason H. Collins, Tulane University
Dr. John Harrod, Chicago, Lying-in Hospital
Dr. Ralph V. Platou, Tulane University
Dr. Victor C. Vaughn, University of Georgia School of Medicine
Dr. James M. Wilson, University of South Carolina
Dr. John E. Savage, University of Maryland

Plans are now in progress to resume this meeting in September of this year.

The maternal mortality for the State of Florida for 1957 was 6.1 per 10,000 and the national average is 6.0. There were 62 maternal deaths in 1957 and 64 in 1956. Seventeen of these were white or 2.3 per 10,000, and 45 were colored or 15.5 per 10,000 live births. The birth rate for 1957 was 104,134 while in 1956 there were 96,969 births, or an increase of 7.4 per cent.

The death rate among the whites is far below the national average and the colored is two and one-half times the national average. Every effort will be directed this year toward some program of reducing the colored maternal mortality.

We are deeply grateful for the help we have had from our sponsors in promoting this meeting. I would like especially to express our appreciation to the State Boards of Health in each participating state, and particularly to Dr. Wilson T. Sowder, Dr. Edward L. Flemming, and to Mrs. Alma Lee Cochley of the Florida State Board of Health.

Dr. Chunn: "The Report of the Committee on Child Health is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Russell B. Carson.

Motion carried.

Report of Committee on Child Health

WARREN W. QUILLIAN, *Chairman*

The Committee on Child Health serves largely as an advisory group with interested organizations whose efforts are primarily aimed at the betterment of health in children from birth through the early school years. Programs are most effectively accomplished at the local level, with the aid and support of physicians through their county medical society. Much of our work has been initiated by others. Guidance and supervision have been provided when requested. The Florida Pediatric Society, through its Committee on the Fetus and Newborn, has stimulated a renewed interest in improvement of standards for the care of the newborn throughout the state. Members of the Child Health Committee have participated in this work. The sixteen Centers for poisoning control established by the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society in strategic locations throughout the state are serving their local areas well. Effectiveness of these facilities depends largely upon the education of public and physicians alike to their practical value. These centers are simply emergency stations for diagnosis and therapy under the supervision of local physicians.

A considerable amount of emphasis has been placed during the past year upon continuing health supervision of the child from early infancy through the school years. Carefully planned programs on school health have been considered in cooperation with the Bureau of Health Education of the American Medical Association. In December, 1957, Dr. Fred V. Hein, consultant on Health and Fitness for that organization, met by invitation with representative groups at Miami, Jacksonville and Gainesville. These groups represented the Florida Medical Association, the Child Health Committee, the Florida Public Health Association, the State Department of Education and other facilities interested in the betterment of child health. The chief purpose of these discussions was consideration of the aims and purposes of a statewide Council on Youth Health and Fitness. It is planned to work with the Junior Chamber of Commerce as a partner in their efforts to formulate a program on Youth Health and Fitness. Emphasis was placed upon the fact that such a Council should not interfere with the professional prerogatives of member groups or recommend programs and activities that, in the opinion of the professions concerned, would be contrary to acceptable medical practice, recognized public health procedures or good educational policies. This is the goal envisioned by all of us interested in working with the program of the President of the United States toward improvement of physical, emotional and spiritual fitness of the nation's youth.

Your Committee was represented at the sixth National Conference on Physicians and Schools held at Highland Park, Ill., in late October, 1957. Youth fitness and how it can best be achieved was the major theme at the meeting attended by approximately 225 physicians, public health officials, educators and representatives of related organizations, who participated in round table discussions at the conference. It is believed that the medical profession should aid any sound or worthwhile programs formulated. Teamwork is necessary in the field of school health. The key to success in any national program lies in active participation and cooperation with local health plans adapted to community needs. The Committee on Child Health believes that our local problems of school health need the leadership and active interest of the physicians of Florida. Other groups involved in the solution of these problems are anxious to have constructive, intelligent guidance and help.

Specific recommendations for any new program are not being made at this time. But, your Committee on Child Health makes an earnest plea to the membership of the Florida Medical Association for their enthusiastic participation in local programs for the betterment of child health which need their leadership and support.

Dr. Chunn: "The Committee recommends approval of the Report of the Board of Medical Examiners in principle, and further recommends the Board of Medical Examiners proceed with the revision of the Medical Practice Act, in consultation with the Association's Committee on Legislation and Public Policy.

"I move the adoption of this portion of the report."

Seconded by Dr. George S. Palmer.

Motion carried.

Report To: Florida Medical Association
From: Florida State Board of Medical Examiners, Homer L. Pearson Jr., M.D., Secretary

The activities of the Board of Medical Examiners seem to increase year by year. Since our last report to you we have examined for licensure 745 doctors, of these 170 failed. We have suspended four licenses, placed one on probation, and at our next meeting, June 28, we will have seven to show cause why their licenses should not be suspended or revoked.

At our last meeting we adopted a new policy relative to foreign graduates. Since the AMA no longer approves or disapproved foreign medical schools it becomes necessary for us to consider each such applicant on an individual basis. They must, however, be successfully screened by the Educational Council for Foreign Medical Graduates and have one year internship or residency in an AMA approved hospital before the Board will consider them.

There are certain other changes in policy which have been suggested by doctors of Florida. We would like to have your opinion on these changes before final action is taken.

It is proposed that we require at least one year internship of all candidates for licensure. Some medical schools require one year internship before degrees are granted. Then, too, it has been brought out that the various licensing boards are examining in an area somewhere between the examinations given for graduation and those given by the specialty boards. So for one to be adequately prepared for a state board examination he should have either an internship or to have practiced for a time.

It was proposed that since we have such a large "back log" of licentiates who practice in other states, and it is growing each year, we should declare null and void all licenses which are not used after a period of eight to ten years.

It was proposed that since the physician populations was growing to such large proportions the Medical Board should assume greater disciplinary prerogatives and employ investigators and or deputies to be under the jurisdiction of the Board rather than under the State Board of Health; that the annual registration fee be raised from $1.00 to $5.00 or $10.00 and that such registration be with the Medical Board rather than the Board of Health, and that this fee be used in the proposed increased disciplinary activities. Since such increased activities would make necessary the employment of a full time executive secretary, it is proposed that such a secretary be employed; that he be a medical doctor and be paid a salary of $12,000.00 to $15,000.00 annually, and that he not be an appointed member of the Board but be appointed by the Board.

It was proposed that we recommend the abolishment of the Basic Science Board since the creation of that Board had failed to restrict the licensing of those irregular practitioners which it was created to restrict. It is further proposed that the entire Medical Practice Act be rewritten for the purpose of modernizing it and a re-evaluation of the subjects to be examined in etc. The National Federation of State Medical Boards has prepared such a medical practice act to be used as a guide for those states which feel the need for rewriting their act.

There is a paragraph in our law which reads as follows: "Every person practicing as a resident physician, assistant resident physician or intern in any hospital in this state, shall register with the state board of health showing the date upon which he started to practice as aforesaid within this state. Every hospital employing a resident physician, assistant resident physican or intern shall, on January 1st and July 1st of each year, furnish the State Board of Health with a list of their said employees. No person may be employed or act as a resident physician, assistant resident physician or intern in the hospitals of this state for a period of more than three (3) years, unless he shall become duly licensed as a physician by the Board. Any person violating this subsection shall be deemed guilty of a misdemeanor."

The purpose of the law is to prevent the practice of medicine in Florida without a license. Many of the smaller hospitals which do not have a training program but who employ house doctors have difficulty in filling these positions with recent graduates from approved medical schools. Therefore, they employ graduates of unapproved and foreign schools who are not qualified to be accepted by the Board. Actually these unqualified persons should not be allowed to become house doctors because they are practicing medicine and not getting accredited training. It is not the purpose of the law to cramp the training program of any accredited hospital. We, therefore, adopted the following resolution:

> "Whereas, admitting that internship and residency in the state is in fact a temporary license to practice medicine; be it Resolved, That all graduates of foreign medical schools, citizens and non-citizens, be required to be screened and approved by the Educational Council for Foreign Medical Graduates before beginning any internship and/or residency program in Florida. This does not apply to graduates of Canadian medical schools.
> Resolved, further, That no foreign medical graduate shall remain in a Florida hospital for more than three years unless satisfactory proof is furnished the State Board of Medical Examiners that he is engaged in an approved residency training program requiring up to a maximum of five years."

Every once in awhile we hear the complaint that we are allowing too many doctors to come into our State. We know that in some sections there are too many and in others not enough.

Our first duty is to the people of Florida and we are making every effort to furnish them with an ample supply of good medical care.

We hope you will consider all these matters and give us the benefit of your thinking.

Dr. Chunn: "The Report of Representative to Student A.M.A. Convention is approved as presented.

"Mr. President, I move the adoption of this portion of the report.

Seconded by Dr. Anderson.

Motion carried.

Report on the Eighth National Convention of the Student American Medical Association

Doctor Roberts and members of the House of Delegates:

It is a great privilege and pleasure for me to deliver this report of the Eighth Annual Convention of the student American Medical Association which was held in Chicago on April 30 through May 4.

As in past years, a great many items of business were deliberated and it has been necessary to select those in which this House of Delegates would be more interested.

It was indeed stimulating to learn that, as a direct result of a resolution passed at last year's Convention, the World Medical Association is in the process of establishing a depository for credentials of physicians throughout the world in order to protect against loss in the event of a major catastrophe. The Student American Medical Association became interested in such a commission in lieu of the plight of many Hungarian doctors who fled their homeland, leaving behind their credentials. Since they could not prove themselves to be physicians they could not practice medicine in their new-found homes.

A member of the Executive Council of the Student American Medical Association will now act as an official observer to the International Federation of Medical Student Associations. The latter is a federation representing medical student organizations of more than 20 nations

and is recognized by the World Medical Association and by the United Nations Educational, Scientific, and Cultural Organization.

Of the several items pertaining to medical education the Student American Medical Association will endeavor to assist the Association of American Medical Colleges in setting up more uniform policy of acceptancy and deposit fees for applicants to medical schools.

A national committee with representatives from the Student American Medical Association, the American Medical Association, the American Personnel and Guidance Association, the Association of American Medical Colleges, and like-organizations is in existence and is preparing plans for study of pre-medical and pre-college counseling programs.

A successful National Medical Education Week is now one of the prime goals of the organization, both on the national and local levels and a good deal of effort shall be expended in stimulating interest in medicine among the upcoming generations.

Investigation of low-cost group automobile insurance for medical students and further investigation of intern malpractice insurance is slated for the appropriate standing committee during the forthcoming year.

The Student American Medical Association has gone on record as favoring reform in the methods and manner of selection of residents, suggesting that the National Intern Matching Plan be extended to cover selection of residents. It was further resolved to evaluate the need for changing the dates of the end of internships and the beginning of residencies, since considerable difficulty presents under the present system, when travel is involved in going from an internship into a residency.

This year saw new additions to the convention as the expanded scientific program became not just a sidelight, as in the past, but an integral part of the agenda. We were honored with the presence of Dr. David Radner who discussed the paper of Dr. James T. Post, winner of the 1957 American College of Chest Physicians Essay Contest. We were fascinated with Dr. Charles F. Bailey's presentation of "Heart Surgery Today". Dr. Theodore Noehren enlightened us as to what may be expected to turn up on a mass chest X-ray survey — "Everything In The Book." We are treated to a give-and-take x-ray conference with Drs. Herman J. Moersch, J. Maxwell Chamberlain, Benjamin Felson, John R. McDonald, and James A. Wier in attendance. A geriatrics seminar was presided over by Dr. Edward J. Stieglitz. Endometriosis was discussed at length by Drs. George H. Gardner of Chicago, Louis M. Hellman of New York, Edward C. Hughes of Syracuse, John Rock of Boston and Richard W. TeLinde of Baltimore. Dr. Nicholas J. Eastman presided over a panel on Reproductive Failure. Needless to say, all who had the opportunity to hear these men were greatly impressed and stimulated.

A second new feature of the convention was the scientific exhibits by medical students, interns and residents. Prizes were awarded for the best in each division.

On behalf of the students of the University of Miami School of Medicine, I wish to sincerely thank the Florida Medical Association for making it possible for us to be represented at the National Convention, and join with the University of Florida in thanking you for permitting this report to be presented to the House of Delegates.

"Mr. President, I move the adoption of this entire report as amended."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Report of Reference Committee No. 2

The Chair called for the Report of Reference Committee No. 2, Dr. Robert F. Dickey Chairman.

Dr. Dickey: "Mr. President and Members of the House of Delegates:

"Your reference committee gave careful consideration to items referred to it and makes the following report:

"The Report of the Committee on Conservation of Vision was approved with the amendment that the last paragraph be deleted as this subject was considered by Reference Committee No. 4. The committee was highly impressed by the feasibility of the Atlantic City Eye Test which was demonstrated by Dr. Marion W. Hester.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward.

Motion carried.

Report of Committee on Conservation of Vision

CARL S. McLEMORE, *Chairman*

This Committee recommends that the Florida Medical Association advocate "The Atlantic City Eye Test" as the most complete and practical method of visual screening of school children now available. It is recommended that children failing the test be given a re-examination before sending a note home advising examination by an eye specialist. With the use of "The Atlantic City Eye Test" and with a policy of re-examining the failures, the percentage of over-referrals can be maintained at a minimum.

The Committee recommends that this portion of its report be transmitted to the Superintendent of Public Instruction of the State of Florida and the Florida State Board of Health.

Dr. Dickey: "The Report of the Committee on Medical Education and Hospitals, and the supplemental report of this Committee, are approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Anderson.

Motion carried.

Report of Committee on Medical Education and Hospitals

JACK Q. CLEVELAND, *Chairman*

Your Committee had a called meeting in Jacksonville on Jan. 12, 1958 for the purpose of discussing the rules and regulations to be adopted by the State Board of Health to implement the Mandatory Hospital Licensure Law passed by the 1957 session of the Florida Legislature. Our Committee was asked for recommendations by the Hospital Licensure Advisory Council to the State Board of Health. This Advisory Council is to meet in March 1958 to recommend a final draft of the Rules and Regulations. Your Committee made certain recommendations and, in fact, Mr. Parham and others made a rough draft of proposed revisions to the present Hospital Licensing rules, regulations and standards. This draft consisted of some 58 typewritten pages. Your Committee recommended to the Advisory Council that these changes be incorporated in the new rules and regulations.

Your Chairman was unable to attend the meeting in Chicago in January of the American Medical Education Foundation State Chairmen. However, the number of contributors to the Foundation in 1957 from Florida was 243 as compared to 73 in 1956. The amount contributed by Florida physicians and others in 1957 to the Foundation was $6,460 as compared to $4,640 in 1956. These figures are very encouraging and indicate an almost 50 per cent increase in funds given. However, in comparison with other states of similar size, the figure is small. As I have stated in my report for the past two years, your Chairman believes that the question of an assessment by the Florida Medical Association for the Medical Education Foundation should be seriously studied. Many state medical associations have made such an assessment — California and Illinois, for example. Even a $5 assessment would double our 1957 total to the Foundation.

Supplement

The Advisory Hospital Council to the State Board of Health for Hospital Licensing met on March 26, 1958. A set of interim standards to implement the mandatory hospital licensing law were adopted. The basis for these standards is an outline of the Rules and Regulations of the Joint Commission on Accreditation of Hospitals but are not as strenuous.

It is not the intent of the Advisory Council to close hospitals but to raise the standards of those hospitals needing this elevation through a process of counseling and education.

Your Association is represented on this committee by two of its members—Dr. Raymond King of Jacksonville and Dr. William Richardson of Graceville.

Dr. Dickey: "The Report of the Sub-Committee on Medical Schools Liaison is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Medical Schools Liaison Sub-Committee

WALTER E. MURPHREE, *Chairman*

At the 1957 Annual Meeting of the Association, the House of Delegates approved the recommendation of the Reference Committee that the Medical Schools Liaison Committee be made a Sub-Committee to the Committee on Medical Education and Hospitals and that its membership be by appointment by the President of the Association.

The Sub-Committee recommended that small local committees within the county societies where there are medical schools be set up. This has been done in Alachua and Dade counties. No report or complaint from these local committees has been rendered to the state Sub-Committee.

The Sub-Committee agreed to meet twice yearly to consider any problems that might arise in the liaison between medical schools and county societies, particularly as regards private practice of geographic full-time faculty members. The limit of their "take home pay" is a permanent agenda of this Sub-Committee. It was not felt necessary to call the Sub-Committee together inasmuch as there has been no changes from last years meeting. The plan for limiting this "take home pay" has not been altered as far as we know. The faculty at the University of Florida College of Medicine is still being assembled; those engaged so far have had their salaries widely publicized. The seeing of private patients will not begin until this fall. No complaints have been heard from Dade County or the University of Miami School of Medicine, where a similar method of handling the income from private patients is in effect.

This Sub-Committee will certainly meet when the necessity arises.

Dr. Dickey: "The Report of the Committee on Medical Economics is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Report of Committee on Medical Economics

ROBERT E. ZELLNER, *Chairman*

The Medical Economics Committee has held no meetings this year. The most important economic matters facing the Association have been of such magnitude as to require the appointment of two committees to deal with them, i.e., the Medicare and the Blue Shield Advisory Committees. The work of the Medical Economics Committee has been largely a continued effort to obtain a group professional liability contract with a responsible insurance company. At the present time and for the foreseeable future, the insurance industry appears to be uniformly adamant in its decision not to underwrite any large group professional liability insurance plans in which the company waives its right to do individual underwriting; that is, to eliminate the so-called poor risks and take only the good risks. The Chairman believes that this project should not be given up as a lost cause but that continued efforts should be made to secure a satisfactory contract. He is convinced that one day the insurance industry will discover that it can operate in this field more profitably and more satisfactorily through the Association than through the individual physician.

The Association health and accident insurance program has not yet reached the sixty per cent participation required by Florida law before all risks, good and bad, can be included. The plan has had excellent experience thus far as is evidenced by an increase in benefits and a revision of rates in the major medical plan effective Feb. 1, 1958. At a reduction in premium rates (except to members over age fifty who have the family contract, in which case there was a slight increase of less than a dollar per annum), the amount of insurance coverage was increased from $5,000 to $10,000 and the age limitation for eligible dependent children was increased from eighteen to twenty-one. As more favorable experience is accumulated there undoubtedly will be further improvements in the contract. All members who need this type insurance are urged to consider carefully the Association plan.

Dr. Dickey: "The Report of Representatives to Industrial Council, and the supplement, are approved.

"I move the adoption of this portion of the report."

Seconded by Dr. Fred Mathers.

Motion carried.

Report of Representatives to Industrial Council

PASCAL G. BATSON JR., *Chairman*

The Committee met Dec. 7, 1957, in Jacksonville with representatives from the Railway and Industrial Surgeons, the Plastic and Reconstructive Surgeons and the Florida Orthopedic Society.

The Committee began its review of Workmen's Compensation Fee Schedule in compliance with instructions from the F.M.A. House of Delegates in May, 1957, to "review the Workmen's Compensation Fee Schedule and recommend any changes which may seem indicated."

It was believed that the first step should be to set up a standard nomenclature for the Florida Medical Association similar to the nomenclature listed in the "Relative Value Schedule of California." After setting up a standard nomenclature, each interested specialty group was to be contacted with the request that our Committee be advised of any changes they desired in nomenclature or relative value units, also the conversion factor (multiple) recommended to determine the dollar values of the schedule to be negotiated later with the Florida Industrial Commission. The conversion factor negotiated originally for Medicare was 500 per cent for medical services, radiology and pathology, and 450 per cent for surgery.

Each specialty group was subsequently contacted and requested to advise our Committee before Feb. 15, 1958, of their recommendations to enable us to forward our recommendations to each county medical society for comment before the Florida Medical Association Annual Meeting. It is contemplated that after the county medical societies have had the opportunity to advise our Committee of any changes they desire in nomenclature or relative value units, then the correlated and condensed material could be brought to the House of Delegates in our Committee's Supplemental Report for action.

It is hoped that this plan can be carried out so as to effectively set up a standard nomenclature for Workmen's Compensation and other fee schedules if indicated. It is also believed that by having a set relative value unit, negotiation with the Florida Industrial Commission will be much easier at later dates since only the multiplication factors will have to be negotiated in order to arrive at a set fee schedule.

Supplement

Our Committee has reviewed the Workman's Compensation Average Fee Schedule in compliance with instructions from the FMA House of Delegates, May 1957, to "Review the Workman's Compensation Fee Schedule and recommend any changes which may seem indicated."

A copy of the Relative Value Schedule of California was forwarded to each specialty group with the request that our Committee be advised of any recommendations for changes in nomenclature, relative value units or conversion factor to determine dollar value of the schedule to be negotiated with the Florida Industrial Commission. This information was transmitted to the FMA Advisory Committee to Blue Shield (Committee of 17) when we learned of their progress toward a standard nomenclature and relative value units for the Blue Shield contracts.

The attached nomenclature and relative value units developed by the Committee of 17 in consultation with interested parties, appears to cover very adequately our needs for the Workman's Compensation program. Our Committee recommends the acceptance of the attached nomenclature and relative value units for the Florida Medical Association.

Our Committee further recommends a conversion factor of 5.0 for surgery and 6.0 for medical services of this relative value schedule as a basis for negotiations with the Florida Industrial Commission as the Workman's Compensation Average Fee Schedule.

If this committee report is adopted by the House of Delegates, the committee will proceed with negotiations in consultation with other committees and interested groups of the Association.

Our Committee also recommends that the incoming committee be instructed to consider problems other than fee schedules in Workman's Compensation cases, such as free choice of physician, vocational training coordinated with medical care in the total treatment of the case, and study of the advisability and feasibility of establishing a rating board to determine disability on the basis of the medical record.

Dr. Dickey: "The Report of Grievance Committee is approved as printed in the handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

Report of Grievance Committee

FREDERICK K. HERPEL, *Chairman*

Activities of the Grievance Committee have been carried on largely, as in former years, by the Chairman. No occasion has arisen for a meeting of the entire committee since the last convention of the Association. Copies of relative correspondence have been routinely forwarded to all members of the Committee for their comment.

The majority of complaints, between patient's relatives and attending physician, were on the matter of fees for service and usually in cases which, on investigation, proved to have been of unusually trying nature requiring more than usual medical and surgical care.

The cooperation of the Grievance and Censorship Committees on the local county society level has been, in most instances, prompt and thorough. The larger societies usually led the way in prompt and efficient handling of complaints.

No praise or commendation should be directed toward the state Grievance Committee. Rather, the commendation should be, and is, directed to the local county societies, who are genuinely interested in seeing that all complaints are equitably handled without fear or favor. Some of the complaints could have been avoided, but the basis for complaint largely arose after statement for services had been presented. "Spare no expense" and "do everything possible" changed to complaints after the service had been rendered and the patient had left the hospital.

Deaths in certain diseases and afflictions cannot always be prevented. In very few instances was there criticism of the quality of medical care.

It is noteworthy that few complaints have arisen where an efficient county medical organization exists. The ratio of complaints to total patients cared for, either in or out of hospitals, is very small indeed and reflects creditably on the services rendered by Florida physicians. It is, of course, true that many complaints are satisfactorily handled locally and never reach the attention of this committee.

The Chairman of this committee feels that reference of complaints directly to the county society committees would speed up and facilitate prompt investigation. Delay only results by passage through intermediate offices and committees before reaching destination. Your Chairman feels that too much time is consumed in acting merely as a forwarding officer. The state Committee is not set up or qualified to conduct local investigations and can therefore act only in an advisory, coordinating or review and appeal committee.

Dr. Dickey: "The Report of the Committee on Nursing and its supplement are approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. McLemore.

Motion carried.

Report of Committee on Nursing

THOMAS C. KENASTON, *Chairman*

The function of the Committee on Nursing is to serve in an advisory and liaison capacity with nursing groups and to keep the members of the Association informed of major problems and trends in nursing and nursing education.

Your Committee has joined with the Florida Hospital

Association, Florida Public Health Association, Florida League for Nursing, Florida Nurses' Association, and the Licensed Practical Nurses' Association in forming the Florida Joint Committee for Improvement of Patient Care. The major purpose of this Joint Committee is to discuss informally activities which will contribute to improvement of the care of the patient. This Joint Committee held two meetings during the past year, one for organization purposes and the other to assist in recruitment of student nurses.

Two members of your Committee have served on the State Advisory Committee for Practical Nursing Education. This latter Committee is Advisory to the State of Florida, Department of Education.

We call attention to the development of practical nurse education with 15 approved schools now in operation in Florida. There are nearly 8,000 practical nurses licensed in the state. A proposed Practical Nurse Program now under consideration would make available to senior high school students, desiring to enter the field of practical nursing, an opportunity to complete a portion of their training while pursuing a high school diploma. Under the program, the course would be organized in technical high schools to provide the preclinical phase of training during the senior year and the clinical portion in the hospital immediately after graduation.

Federal subsidies are available for originating and equipping additional schools for training of practical nurses in counties where clinical facilities are available. Information concerning the establishment of such schools is obtainable through your Committee.

The attention of the members of this Association is called to the program originating in Escambia County under the guidance of the Escambia County Medical Society, whereby the Board of County Commissioners under a Permissive Act has set up a revolving loan fund to students entering nurses' training. It is suggested that further measures of this nature will materially affect the ever increasing shortage of nursing personnel.

Your Committee believes that there is a definite improvement in relations resulting from the close liaison between medical and nursing groups. It leads to a better understanding of mutual problems and opportunity for discussion of differences on a friendly basis of mutual benefit to all.

Supplement

This supplemental report is submitted by request of the Board of Governors of the Florida Medical Association.

For a number of months an organization known as the American Registry of Doctor's Nurses has been operating in Florida with the address of P. O. Box 88, Marianna, Fla. They have listed Mr. Ralph Z. Bell as president and they stated their goal to be to "raise the standards of the doctor's nurses." Through efforts of the Florida Medical Association and the Florida State Board of Nursing, this organization was called to the attention of the Attorney General of the State of Florida. Under date of 8 April 1958 the Attorney General ruled that the organization known as the American Registry of Doctor's Nurses was illegal under the Nursing Practice Act of the State of Florida. The organization was also investigated by a representative of the Federal Trade Commission who was interested primarily because the organization was operating interstate and operating in a profit making capacity by the sale of membership pins.

The latest information available to us is that the attorney for the American Registry of Doctor's Nurses has advised the Attorney General, The Honorable Richard W. Ervin, that this Registry has temporarily suspended its program in the State of Florida.

Dr. Dickey: "The Report of the Committee on Blood and the supplemental report of this committee are approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Ralph Herz, of Monroe.

Motion carried.

Report of Committee on Blood

JAMES N. PATTERSON, *Chairman*

The Committee on Blood has had no meeting at the time of this report. However, it is planned to call a meeting before the 1958 Annual Meeting of the Florida Medical Association to consider the recommendations concerning Replacement of Blood by Medicare patients made by the Escambia County Medical Society and Reference Committee No. 2 and approved by the 1957 House of Delegates. A supplementary report will be rendered at the Annual Meeting.

Two of the most important developments in the field of blood banking have occurred nationally. Foremost is the heartening sign that the Joint Blood Council seems to be coming of age. This Council, which is composed of two members from each of the following organizations —the American Medical Association, the American Hospital Association, the American Society of Clinical Pathologists, the American Association of Blood Banks and the American National Red Cross, has been very disappointing in its failure to assume the leadership for which its organization was intended. It at long last has taken a strong stand in regard to the National Blood Program in urging the Office of Defense Mobilization to contract directly with the individual member banks of the American Association of Blood Banks, giving these banks, which collect approximately one-half of the blood collected in this country, full stature and responsibility as contractors and not as subcontractors to the quasi-governmental agent, the American National Red Cross.

An equally important sign is the increased awareness of the Joint Blood Council of the dangers inherent in "Blood Insurance" clauses in health insurance policies whereby the insured is reimbursed in dollars for each pint of blood received. Such a program, if widespread, can hardly help but have a depressing effect upon the recruitment of volunteer donors. To combat the increasing trend to blood replacement clauses in insurance policies, the Council is urging that there be local expansion of the blood credit system (Donor Clubs) for groups and individuals contributing blood in advance of need. It is also urged that a pool of paid donors be developed in each blood bank so that blood can be purchased with the money paid by those who fulfill their obligations with cash and to fill in the gaps, especially of rare types of blood, with blood supplied from voluntary donors. One other very effective means of keeping the blood bank solvent is for each individual physician to urge that the patient and his family assume the obligation of replacing unit for unit the blood used.

We are most fortunate that the Florida Blue Cross policies provide only for payment to hospitals for the service charge covering the cost of administration, cross-matching and processing, but not for the replacement of blood. This was a wise decision and it is hoped that there will be no change in this provision.

Supplement

The Committee on Blood met today and discussed the recommendation concerning replacement of blood by Medicare patients made by the Escambia County Medical Society, modified by Reference Committee No. 2 and approved by the 1957 House of Delegates.

The problem presented has been discussed with the Medical Director of three Regional Blood Banks as well as with Dr. John D. Milton, Chairman of the Medicare Medication Committee of the Florida Medical Association.

A review of the policies of the various blood banks of the state shows there is no unanimity of replacement policy. Therefore, the Committee on Blood recommends that the problem be resolved on a local level rather than by attempting to set up a state-wide Medicare Blood Bank Account.

An example of a local solution of this problem is that of the Jacksonville Blood Bank which has worked out a very satisfactory arrangement whereby the Naval Air Station maintains an account sufficient for replacement. On the other hand, in Tampa, rather than have McDill Field collect blood for the Southwest Florida Blood Bank, the hospitals collect the penalty charge and this money is used to purchase blood.

Dr. Milton concurs with the opinion of the Committee on Blood that we should not disturb the Medicare Program with this problem.

Dr. Dickey: "The entire reference committee wishes to commend the committee chairman and their committeemen for the fine reports and obvious work that has been done during the past year and particularly wishes to commend Dr. Pascal G. Batson Jr. for the vast amount of work done by his Committee on Representatives to Industrial Council.

"Mr. President, I move the adoption of this entire report as amended."

Motion seconded and carried.

Report of Reference Committee No. 3

Dr. Roberts: "I would like to invite my good friend, Herbert White, the Chairman of Reference Committee No. 3, Finance and Administration, to give his report."

Dr. White: "Mr. President, House of Delegates, Guests:

"Your committee No. 3 on Finance and Administration were all present and I wish to make the following report.

"The Resolution on Discontinuance of District Meetings is approved as printed in the Handbook. With reference to the last paragraph of this resolution, attention is called to the fact that Chapter VI, Section 2 of the By-Laws provides that Councilors are urged to visit each county society in their district at least once a year.

"I move the adoption of this portion of the report."

Seconded by Dr. Palmer.

Motion carried.

Resolution

Discontinuance of District Meetings

For several years there has been evidenced by progressively poor attendance, a lack of interest in the District Meetings. Not infrequently, only a few physicians residing in the locality of the meeting take the time to participate unless they are in an official capacity. It is believed, in the light of this situation, that the funds expended by the Florida Medical Association to defray the expenses of the officers to attend these meetings would have a far more beneficial effect if used to send some officer-representative to appear before each County Medical Association sometime during the year.

Be It Therefore Resolved, that the Hillsborough County Medical Association recommend to the Florida Medical Association that the District Meetings be discontinued.

Be It Further Resolved, that some officer or representative of the Florida Medical Association visit each County Medical Association yearly to act as a liaison officer between the two groups.

Respectfully submitted,
James A. Winslow Jr., *Secretary*
Hillsborough County Medical Association

Dr. White: "The Resolution on nomination of President-Elect of the A.M.A., which was read to the first House of Delegates by Dr. Homer L. Pearson Jr. is approved.

"I move the adoption of this portion of the report."

Seconded by Dr. Gordon H. McSwain.

Motion carried.

Resolution

At the meeting of the A.M.A. in San Francisco next month it will be my honor to nominate I believe the next president-elect of the A.M.A. The person I will place in nomination is a member of this House of Delegates. Your representatives to the A.M.A. House of Delegates are allowing me this privilege because I am older in the service than they are. So, I would like to make this nomination in the name of the President, the House of Delegates of the Florida Medical Association, in fact in the name of the doctors of Florida, as well as for Francis Holland and Reuben Chrisman.

Therefore, be it resolved that the House of Delegates of the Florida Medical Association unanimously instructs Homer L. Pearson to nominate Louis M. Orr for president-elect of the American Medical Association at his first opportunity.

Homer L. Pearson Jr.

Dr. White: "The resolution on the selection of hotels for the Annual Meeting, which was presented at the first House of Delegates by Dr. Walter C. Jones, is approved in principle and referred to the Board of Governors to take whatever action they deem appropriate.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Robert E. Zellner, of Orange.

Motion carried.

Resolution

WHEREAS physicians being busy individuals allocate their time to conform to situations demanded, and

WHEREAS reservations for room accommodations are made in good faith and if necessary deposits are given, and

WHEREAS great inconveniences and disruptions have been caused by the upset of the above conditions during the last two meetings of the Florida Medical Association in Miami Beach; therefore be it

RESOLVED that the Board of Governors of the Florida Medical Association be instructed to refuse to obligate

themselves for Annual Meetings of the F.M.A. at any hotel that refuses to protect and preserve their obligations to honor reservations made and designated to the membership by these hotels.

It is suggested that the action of the House of Delegates of the F.M.A. on this matter be sent to the Miami Beach Chamber of Commerce, the Miami Beach Hotel Association and the Convention Bureau of Miami Beach.

Walter C. Jones, M.D.

Dr. White: "The resolution on location of called meetings of the House of Delegates, presented at the first meeting of the House of Delegates by the Broward County Medical Association, is disapproved as the committee believes that the time and place for called meetings should be left to the discretion of the President and the Board of Governors. Gentleman, this is taken care of in our By-Laws.

"I move the adoption of this portion of the report."

Seconded by Dr. James T. Cook Jr., of Jackson-Calhoun.

Motion carried.

Dr. White: "The committee recommends approval of the President's address with commendation for his inspirational message.

"I move the adoption of this portion of the report."

Seconded by a chorus of voices.

Motion carried.

(Complete text of the President's Address will be found in this issue, page 19.)

Dr. White: "The committee recommends approval of the report of the Board of Governors as published in the Handbook, and the Supplemental Report as presented at the first meeting of the House of Delegates.

"I move the adoption of this portion of the report."

Seconded by Dr. Clyde O. Anderson.

Motion carried.

Report of Board of Governors

WILLIAM C. ROBERTS, *Chairman*

During the administrative year and prior to the publication of this report, four meetings of the Board have been held. (In 1957, May 8, Hollywood; May 26, Jacksonville; October 30, Orlando. In 1958, February 9, in Jacksonville.) A fifth meeting has been scheduled tentatively for April, which will be covered in a supplement to this report to be presented to the First Meeting of the House of Delegates on May 11.

My deep gratitude is extended to the members of the Board who have attended meetings at great sacrifice of time and convenience at their personal expense. The graciousness with which they accept this assignment and the conscientious consideration they give the numerous problems is indeed refreshing and encouraging.

Recommendations

1. Annual Meeting Sites

(a) 1959—Return to Americana

At the 1957 meeting, this House accepted the recommendation of the Board that the 1959 meeting be held in Jacksonville, provided adequate facilities were determined to be available. There is still a question whether the facilities in Jacksonville will be adequate, also, it is quite indefinite as to whether the additional facilities already under construction will be ready by the time of the 1959 Annual Meeting. For this reason and because at the time of the writing of this report it appears that the facilities and services of the Americana will be adequate and satisfactory, your Board recommends returning to the Americana in 1959.

(b) 1960—Jacksonville

Again your Board is requesting approval of Jacksonville as the site for the 1960 Annual Meeting with the same proviso as last year, that the Board first make certain that facilities will be adequate and satisfactory. If it becomes necessary to make another selection, recommendations to that effect will be presented to the House at the 1959 Annual Meeting.

2. Revision of Constitution and By-Laws

At the 1957 meeting, this House approved a recommendation by President Francis H. Langley that a Sub-Committee to the Board of Governors be appointed to study and rewrite the Constitution and By-Laws and to present them to the House of Delegates at the next Annual Meeting for consideration. This project has been turned over to the Executive Committee of the Board, but it is a sizable task and the Executive Committee has been able to progress only to the extent of a first draft of the revision. It was deemed inadvisable by the Board to rush a detailed project of this significance. It is the first major revision of the Constitution and By-Laws in over 30 years, and when completed should not only take care of the present, but, properly designed and adequately flexible, should provide for the foreseeable future. Thus, your Board requests an extension of time until the Annual Meeting in 1959, at which time a complete revision will be presented for your consideration. It is the intention of the Board to have the final draft in time to place it in the hands of the county society officers and the delegates far enough in advance of the Annual Meeting for adequate study.

Forand Bill

Believing that the members of the Association are opposed to indiscriminate expansion of the Social Security program, the Board on February 9 took action opposing in principle the Forand Bill (H.R. 9467) and similar legislation.

Medicare

In compliance with the instructions of the House of Delegates at the called meeting on December 8, 1957, the contract with the Office for Dependents' Medical Care has been extended through January 31, 1959. Agreements are in accord with instructions of the House. In a separate report, Dr. John D. Milton, Chairman of the Medicare Mediation Committee, and Chairman of the Negotiating Team, will bring the House up to date on Medicare.

Medicare has been the major item at Board meetings during the past year. A large percentage of the time during the 1957 meetings was allocated to Medicare. The May 26 meeting was called for the specific purpose of implementing and carrying out the instructions of the House of Delegates. This program has eaten heavily not only into the time of the Board of Governors, but into that of the personnel of the executive staff as well. It is to be hoped that it will now settle down into a more definite pattern and that the work load on the Board,

the Medicare Committee and the Executive Office will be substantially reduced.

Annual Meeting Program

Upon the recommendations of the Executive Committee and the Chairman of the Scientific Work Committee, Dr. George T. Harrell Jr., your Board approved a schedule and program for the 1958 Annual Meeting identical to that followed in 1957. These were published in the April Journal and may be found in your official program.

In accordance with your instructions, the Annual Banquet has been restored this year and is scheduled for the Bal Masque Room on Tuesday evening, May 13, at 7:30 p.m. Included in the price of the ticket will be a floor show provided by the hotel. It is with some trepidation that the Board considers the inclusion again of a banquet in our Convention activities. Prices for acceptable banquet meals are fast becoming prohibitive. Whether this type of activity should be continued will have to be determined largely by the response this year. If the attendance should be small due to the cost, we believe that the results will not be satisfactory to the membership, and the Association is likely to be faced with a deficit for this particular activity.

President's Reception

It has been deemed advisable to change the name of the social activity known previously as the "Patio Party" to that of the President's Reception. It is to be a party in honor of the President, to which each member of this House of Delegates, the officers, the members of the Board of Governors and the delegates to the American Medical Association will receive one complimentary ticket each. Additional tickets may be purchased at the regular rate.

In recognition of the substantial contribution that the technical exhibitors make to the success of the convention, the policy of granting each exhibiting firm two complimentary tickets to the reception will be continued.

Medical District Meetings

The question has been propounded from several sources as to the advisability of continuation of the Medical District Meetings as they are now conducted. The rather unfavorable experience of the last several years, with regard to interest and attendance has promoted considerable thought and discussion. On February 9, the Board elected to assign the study of this problem to the Council and directed the Chairman of Council to call a meeting with a view to submitting recommendations to this meeting of the House of Delegates. This meeting has been announced but will not have transpired by the time this report goes to press. The recommendations of the Council will be considered at a later meeting of the Board and will be reported in the supplement to this report.

President-Elect of A.M.A.

You are all aware that our senior delegate to the American Medical Association, Dr. Louis M. Orr, is an announced candidate for the office of President-Elect of the American Medical Association, subject to the vote of the A.M.A. Delegates at the June Meeting in San Francisco. Your Board has given full endorsement and enthusiastic support to Dr. Orr's candidacy and plans to continue that assistance.

Committee of Seventeen

In 1956 the House of Delegates established a state physician's committee on Blue Shield, now known as the Association's Advisory Committee to Blue Shield and normally referred to as the Committee of Seventeen. This committee, under the chairmanship of Dr. Henry J. Babers Jr., has been diligently and meticulously studying this problem for the past two years. They have constantly kept the Board of Governors advised, reporting to it frequently and obtaining the approval of the Board of its plans and procedures. In a separate report, Dr. Babers will tell the members of this House what has been accomplishd in the past two years and will have recommendations which should be carefully studied by every delegate. This issue is so vital and so important to all physicians and the decisions reached here will be so far-reaching, that a Reference Committee has been appointed to consider only items pertaining to Blue Shield. Consult your program for the time and place of the meeting of this Reference Committee.

Florida Society of Internal Medicine

To conform to a provision of the By-Laws that requires all specialty groups to be approved by the Board of Governors before being officially listed in the records of the Association, the Board on October 30 gave formal recognition to the Florida Society of Internal Medicine.

Arthritis and Rheumatism Foundation

In compliance with the request of the Executive Director of the Arthritis and Rheumatism Foundation, the Board on February 9, directed the President to appoint one physician from each of the eight Councilor Districts to serve on the Board of Directors of this organization.

Commendation

During the past year, a former President of the Association terminated seventeen years of service as a member of the Florida State Board of Health, sixteen of which were in the office of President. In recognition of the outstanding service to the state and to his profession, the Board approved a resolution of commendation to Dr. Herbert L. Bryans, of Pensacola.

Requests to the Board

The Board of Governors on February 9 also gave approval to (1) the recommendation of the Chairman of the Committee on Legislation and Public Policy, Dr. H. Phillip Hampton, that Governor Collins be requested to establish a Governor's Medical Committee on Health in Florida; the function of such committee to be to consider such problems as coordination of all state agencies rendering medical services, the role of all voluntary health agencies operating in the state, the policies on outpatient clinic care of indigents, nursing home care, chronically ill and aged, maximum utilization of personnel trained in the health field, air pollution and medical aspects of the atomic energy program, and similar problems; (2) the establishment of a School Health Medical Advisory Committee, which would serve in an advisory capacity to the State Board of Health and the State Department of Education, and would provide guidance in all matters concerning school health, the membership of this committee to be selected by the Association, subject to approval of the state agencies; (3) a request of the Chairman of the Mental Health Committee, Dr. Sullivan G. Bedell, to seek a research grant to study and determine the most effective means to render out-patient psychiatric care and other mental health problems in Florida, specifically with reference to out-patient psychiatric care. for indigents and the number of beds needed for psychotic children in state institutions, provided Federal funds are not requested.

Asian Influenza

In the face of a threat of a possible serious epidemic of Asian influenza and in compliance with the suggestions and recommendations of the American Medical Associa-

tion, the Board directed the President to establish an Asian Influenza Committee. This task was assigned to Dr. Richard G. Skinner Jr., Chairman of the Poliomyelitis Advisory Committee. Dr. Skinner's report follows:

Asian Influenza Committee

RICHARD G. SKINNER JR., *Chairman*

This committee was constituted in August of 1957 by Dr. Roberts, and consisted of one official member—the undersigned—who had the very able assistance of Dr. James O. Bond, of the State Board of Health, and the office staff of the Florida Medical Association.

Initially, after a meeting with the above-mentioned people, a memo was sent to all members of the Medical Society, outlining the program in regards to Asian Influenza. This program was essentially the same program outlined by the American Medical Association, but adapted to Florida.

On September 13, a memo was sent to the Presidents and Secretaries of the Medical Societies stating that the epidemic was a real possibility, and that it was essential to vaccinate key personnel in a certain sequence, which was outlined. The problem of group immunizations was left to each individual Society to settle as they best saw fit. During the following months, the committee maintained surveillance of the situation with the very excellent assistance of the State Board of Health to determine if the situation was getting out of hand in any particular locality. During the fall months, Asian Influenza reached epidemic proportions in numerous parts of Florida, and was associated with a great deal of morbidity, but the mortality rate was as previously expected.

A film on Asian Flu was shown at Miami and in the Tampa-St. Petersburg area in September through the efforts of the staff of the Florida Medical Association.

Information was disseminated to all of the Medical Societies, stating that the American Red Cross was willing to cooperate with the Societies in cases of an epidemic, and stated the manner in which the cooperation would take place.

The attitude of the committee towards the Influenza vaccine was essentially that other than the key personnel, no strenuous effort was to be made to get people vaccinated. If the vaccine became more available, the decision would be left up to each individual doctor as to how important he thought it was to vaccinate his individual patients.

In October, 1957, Dr. Wilson T. Sowder of the State Board of Health, and I went to Tallahassee to discuss the problem with the Governor's Office, and to answer any questions he might have in regards to this. This was by request of the Governor, himself.

Again I would like to thank the staff of the State Board of Health, and Dr. Bond for their tremendous assistance in the functioning of this Committee.

Sub-Committee to Board of Governors on Veterans' Care

FREDERICK H. BOWEN, *Chairman*

During the calendar year 1957, 32,366 veterans received medical treatment by fee-basis physicians in the State of Florida. The physicians of Florida received $329,666 for their services. Also, during the year meetings were held with the State Medical Officer of the Veterans Administration in an attempt to elevate the fee schedule. These negotiations are proceeding.

A prime effort of the local V. A. Committees should be to get the Veterans Administration to stop treating non-service connected disabilities. It should be emphasized that economy in our government is necessary to provide money for National Defense. Money saved by economizing in the field of non-service connected veterans' medical benefits could well be diverted to National Defense.

Supplement

This supplement to the Report of Board of Governors is in addition to and a part of the original report as printed in the Handbook. It is submitted to include a meeting of the Board in Jacksonville on April 13, 1958 and May 11, 1958.

At the first meeting careful consideration was given to numerous items and the actions of the Board are herewith submitted for the consideration of the House of Delegates.

Dicontinuance of District Meetings

In view of apparent declining interest in the annual District Meetings as reflected in the low attendance and in response to inquiries from county medical societies and individual members, your Board requested the Chairman of Council to make a study of this problem. Your Board approves the recommendations of the Council that the District Meetings be discontinued. With respect to the Council's further recommendation that the District Meetings be replaced by an Interim Meeting of the Association, it is the opinion of the Board that the advisability of this step requires further study. It is suggested that the Board be authorized to arrange for an Interim session if deemed advisable and that it give further consideration to the type of activity which should replace the District Meetings.

Reimbursement For Expenses Incurred on Association Business

In accordance with the instructions of this House of Delegates in a resolution approved at the 1956 Annual Meeting, the Board has continued its study relating to expenses for officers other than the President and Secretary and Committee Chairmen. The Board has authorized that representatives who are requested by the Board or the officers of the Association to make out-of-state trips be reimbursed for actual expenses if they are not paid by some other agency or organization. This is in addition to the amount set aside by the House of Delegates for expenses incurred by the President and the Secretary or their representatives in traveling on Association business. It is the consensus of the Board that extension of this policy of reimbursement for expenses should continue to be a matter for Board consideration, inasmuch as its feasibility and practicability is necessarily limited by the funds available.

Blue Shield Nominations

At the request of the Nominating Committee of Blue Shield of Florida and in accordance with their By-Laws, two nominees for each vacancy on the Blue Shield Board of Directors were selected for presentation to the active members of Blue Shield at its annual meeting on May 12, 1958, at the Americana Hotel. A slate from which these nominees were selected was presented to the Board of Governors by the Blue Shield Nominating Committee, Dr. Eugene G. Peek Jr., Chairman.

Policies on Medicare

Medicare still continues to be an item for consideration at practically every Board meeting and still continues to be excessively demanding on the time of the personnel of the Association's Medicare Mediation Committee and the staff of the executive office. Your Board respectfully recommends adoption of the following policies on Medicare:

1. That the FMA Medicare Mediation Committee continue not to mediate osteopathic fees.
2. That, if osteopaths are to receive the fee schedule, it be sent to them by ODMC and not by our Executive Office.
3. That the Medicare Manual with fees be given only to state societies and the FMA county and state Medicare Committees as a guide for maximum fees.

4. Advise ODMC that the suggestions of our negotiating team are hereby reaffirmed that oral and parenteral medications dispensed or prescribed by physicians to out-patients be the responsibility of the patient.

Practice of Medicine Through an Intermediary

The attention of the Board was called to an apparent attempt to establish a type of contract medicine in which the organization employed doctors to give physical examinations to union members. It proved difficult to obtain accurate information on this organization or about the individual attempting to organize it. The Association's file on this subject is being placed at the disposal of the Reference Committee and it is available to any member who wishes to examine it further. It is the opinion of the Board that this would constitute the practice of medicine through an intermediary and proposes that we recommend to the members of the Association that they do not participate in such practices.

Operating Budget

An operating budget submitted by Dr. Samuel M. Day, Secretary-Treasurer, as amended was approved in the amount of $187,042.09. It further approved the recommendation of the Secretary-Treasurer and the Managing Director, that this total budget be reduced by twenty-five per cent and that the fiscal year of the Association be changed to coincide with the calendar year. This budget then would be for a nine month period ending December 31, 1958. A copy of this budget is on file in the Executive Office and will be made available to any member on request. The audited financial statement of the Treasurer will be published in the July 1958 issue of The Journal.

Disposition of Reimbursement for Collection of AMA Dues

The American Medical Association refunds an amount equal to one per cent of the total amount of AMA dues forwarded to it by the Association. This amounts to twenty-five cents per AMA member. It is the recommendation of the Board that, retroactive to January 1, 1958, all reimbursements received from the American Medical Association for the collection of AMA dues be forwarded to the Florida Medical Foundation.

Resolution
Revision of The Journal

WHEREAS, The Journal of Florida Medical Association is the official organ of the Association and, as such, material published therein is assumed to have official endorsement and,

WHEREAS, this places extreme responsibility upon the Editor unless he has readily available advice and guidance from sources well versed in the policies, procedures and objectives of the Association, and

WHEREAS, the Board of Governors is composed of Association members who meet these qualifications, and who are either elected by the House of Delegates or appointed by an officer elected by the House of Delegates, and are selected in a manner so that a majority of the Board will have served one or more years, and,

WHEREAS, the Board of Governors is specifically designated in the By-Laws to "consider and act upon matters of business pertaining to the Association in the interval between annual meetings,"

BE IT THEREFORE RESOLVED: That Article VII, Sec. 1, of the Constitution, be amended by deletion of the phrases, "an Editor of The Journal" in lines 3 and 4, and "and Editor of The Journal" in line 5; also that Article VII, Sec. 3, be amended by deletion of the phrase "and the Editor of The Journal" in lines 7 and 8.

That Chapter VII, Sec. 2, Board of Governors, in the By-Laws, be amended by adding a subsection 2a designated as "The Journal of The Florida Medical Association." This subsection to read:

The Journal of The Florida Medical Association shall be under the direct supervision and guidance of the Board of Governors. The general policies and procedures of The Journal shall be determined by the Editor, subject to Board approval.

The Board shall select annually from the membership at large an Editor whose duties and responsibilities shall be designated by the Board. The Editor shall appoint annually, subject to Board approval, the assistant editors and an editorial board or staff of at least five members.

The Editor shall appoint, subject to Board approval, a committee on publications, a committee on screening of advertising, an abstract editor and a book review editor, and such other posts and committees as he and the Board shall deem advisable. Individuals filling these assignments shall be considered members of the editorial staff.

The Board of Governors shall employ a managing editor and fix his compensation. He shall be provided with an adequate lay staff of his own selection, the members of which may have collateral duties in the Executive Office. He shall be responsible for the technical and mechanical processing of the publication, and shall carry out the directives of the Editor.

These By-Laws changes shall become effective immediately upon ratification of the appropriate amendments to the Constitution by three-fourths of the component county societies as required by the constitutional provision for amendments.

Resolution
Committee on Aging (or Geriatrics)

WHEREAS, the progress of medical science has significantly lengthened the average life span and thereby increasing the number of older persons in the nation, and

WHEREAS, this has appreciably added to the requirement for medical services for these older citizens, and

WHEREAS, voluntary and governmental agencies are deeply concerned and aggressively active in arranging for necessary care and services for this age group, and

WHEREAS, because of favorable climate and other attractions Florida has become a haven for people planning retirement,

BE IT THEREFORE RESOLVED, that Chapter VII, Section 1, of the Association's By-Laws be amended by adding to the end of the section the sentence, "There shall also be a Committee on Aging (Section 23)," and

Be it Further Resolved, that at the end of Chapter VII of the By-Laws there be added "Section 23, Committee on Aging," which shall read as follows:

> "The Committee on Aging shall consist of five members. The President shall appoint one from each of the four medical districts, one for one year, one for two years, one for three years and one for four years, and thereafter they shall be appointed for four years as their terms expire. The President shall also appoint each year one member at large for a term of one year. The chairman of this committee shall be selected annually by the President.
> The duties of this committee shall be to study the problems of aging persons with regard to adequate and appropriate medical services and facilities, to make recommendations for effecting advisable measures and to work in liaison with acceptable voluntary and governmental organizations or agencies interested in this endeavor."

Report of Sub-Committee to Board of Governors on Blue Shield

Appended hereto is the annual report of the Sub-Committee to the Board of Governors on Blue Shield.

This report was not received in time to present it to the Board at its final meeting of the administrative year on April 13, but your attention is directed to the recom-

mendation of the chairman of this sub-committee that it be discontinued, as its activities and functions are now the responsibility of the Association's Committee on Advisory to Blue Shield, commonly known as the Commitee of Seventeen.

With regard to the second recommendation, that consideration be given to the annual appointment of a member of the Board of Directors of Blue Shield to serve on the Board of Governors in a voting capacity, your attention is directed that currently four members of the Blue Shield Board of Directors are also members of the Association's Board of Governors. Since the inception of Blue Shield, more and more members of its Board of Directors have served concurrently on the Board of Governors.

Report

Russell B. Carson, Chairman

As Chairman of the Sub-Committee to the Board of Governors on Blue Shield, a position which by precedent and custom has been held by the President of Blue Shield of Florida, Inc., and who in reality has constituted a committee of one to act as a liason between the Board of Directors of Blue Shield and the Board of Governors of the Florida Medical Association, I wish to recommend that this Sub-Committee be abandoned and deleted from further appointment.

My reason for making this recommendation is that during the past two years since the formation of the liaison committee of Blue Shield, commonly known as the committee of Seventeen of the Florida Medical Association, there is no longer a need or a function for a Sub-Committee to the Board of Governors. As Chairman of the Sub-Committee, during the past year I have neither been called upon by the Florida Medical Assoication to appear before the Board of Governors in an official capacity for Blue Shield, nor as an appointee of the President of the Florida Medical Association, I have not been requested to officially represent the Board of Governors for the Florida Medical Association before the Blue Shield Board of Directors.

Dr. White: "The report of the Committee on Necrology and its supplement. Gentlemen, you have all heard this report and I would like to say that I think this was one of the nicest things that has ever been done in the House of Delegates for our departed brothers. I would like to thank Dr. Sackett for arranging this service."

Report of Committee on Necrology

J. BASIL HALL, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Texas A. Adams, (Col.), Daytona Beach
Ralph F. Allen, Coral Gables
John D. Bell, Pensacola
Warren A. Brooks, Winter Park
Coleman G. Buford, West Palm Beach
Raymond C. Conklin, Mount Dora
Noah T. Counts, Cocoa
Alfred E. Cronkite, Fort Lauderdale
Simon E. Driskell, Jacksonville
Joseph W. Eaton, St. Petersburg Beach
C. Harold Edmunds, Miami
H. S. Geiger, Kissimmee
Thos. R. Griffin, St. Petersburg
Walter B. Johnston, Winter Park
Lee W. Lerner, Miami
Percy F. Lisk, Fort McCoy
John T. McDermid, Fort Pierce
John S. McEwan, Orlando
Arthur McGugan, Denver, Colo.
John F. Mason, Bradenton
Alexis M. Melvin, Miami
John T. Moore, Tampa
Lucien E. Myers, Winter Park
Robert G. Neill, Orlando
Frank O. Nichols, Miami
Frank W. Nickel, Winter Park
Walter C. Page, Cocoa
Cleveland J. Price, Alford
Joshua M. Price, Live Oak
Merrick D. Thomas Sr., Miami
Julian N. Tolar, Sanford
Walter D. Webb, St. Augustine
William C. Young, Chiefland

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

Supplement

Since the Handbook went to press, the following members have been lost by death:

Benjamin J. Bond, Winter Haven
Oliver C. Brown, Fort Lauderdale
Marvin S. Freedland, Miami
James H. Mendel Sr., Coral Gables
William B. Moon, Crystal River
Harry Moses, Palm Beach
Julius A. Roth, Delray Beach
William Steinman, Miami
Johnson L. Turnage, Crestview

Dr. White: "The Report of the Committee on Advisory to Woman's Auxiliary is approved as printed in the handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Report of
Woman's Auxiliary Advisory Committee

MERRITT R. CLEMENTS, *Chairman*

There has been no formal meeting of this Committee this year. Mrs. Perry D. Melvin, President of the Auxiliary, has consulted the Committee on the advisability of one of their projects which was the giving of an award to the teacher responsible for the inspiration and guidance of the student who won the prize at the State Science Fair for High School Students. This project was approved by the Auxiliary Advisory Committee. From reports heard in general, the Medical Auxiliary under the leadership of Mrs. Melvin is doing an outstanding job for us throughout the state.

Dr. White: "The committee recommends approval of the Report of Councilor Districts and Council, as published in the handbook, and its supplement, as presented to the House of Delegates by Dr. S. Carnes Harvard, Chairman.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Duncan T. McEwan, of Orange.

Motion carried.

Report of Council

S. CARNES HARVARD, *Chairman*

The first meeting of the Council was held in Hollywood, Fla., at the time of the Florida Medical Association's Annual Meeting. At that meeting it was decided it would be necessary to have the four District Meetings on successive days in order to avoid conflicts with other medical group meetings. Accordingly the dates were set as follows: Panama City, October 28; Clearwater, October 29; Orlando, October 30; Fort Pierce, October 31. At this meeting, it was decided that the scientific subject for the program would be "Diagnosis and Management of Gastrointestinal Bleeding." It was suggested that there be two papers on this subject, from the medical and the surgical aspect. It was further suggested that these papers be presented by members from the district where the meeting was to be held. All these papers were well presented and the authors are to be congratulated on their presentation of the subject.

The general sessions at the District Meetings were interesting and two subjects, namely, Medicare and Blue Shield, provoked quite a bit of discussion. The reports by the Deans of the two Medical Schools in the state were interesting and well received. The report by Dr. Edward Jelks on the Florida Medical Foundation was timely and should be given every consideration.

The committees on local arrangements in each place are to be commended for their work. The meetings moved along without any trouble, and the social events and dinners were superb.

The various District Meetings in themselves were top-notch. The one disturbing factor was the poor attendance. One Councilor summed it up in these words, "It seems to me the information and the papers presented at these meetings was something that each of us could ill afford not to hear. I think the lack of attendance is proportionate to the stated complacency that the medical profession is in at the present time. What takes place at these meetings seems so vital to me that almost everyone should attend and every effort should be made to increase the attendance."

There have been more than the usual number of problems dropped into the lap of the Council this year. All these matters have been or are being thoroughly investigated. Some have been straightened out and the Council hopes to have everything adjusted by the time of the May meeting. Some of these problems have been reported to the Board of Governors and a full report will be given them on these matters.

I would like to thank the members of the Council who have been so willing to help and advise on the various problems that have come up, namely Doctors Alpheus T. Kennedy; T. Bert Fletcher Jr.; Gordon H. McSwain; John M. Butcher; Leo M. Wachtel; Don C. Robertson; Ralph M. Overstreet Jr. and Nelson Zivitz.

Supplement

A recommendation was also made to the Board of Governors asking that Chapter VI, section 2 of the Constitution and By-Laws of the Florida Medical Association be brought to the attention of the various County Societies. It was thought that a Councilor could bring to the attention of the County Societies much information concerning the activities of the State Association. The Councilor has had some hesitation about inviting himself to these meetings.

Dr. White: "The Report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward, of Orange.

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. ROCHER CHAPPELL, *Chairman*

Your Advisory Committee to Selective Service for Physicians and Allied Specialists was deactivated by the Federal government on July 1, 1957. All of these committees are on a stand-by basis, awaiting further call to activity on the National Selective Service Board.

We have not had any activity since that time.

Dr. White: "The Report of the Committee on Civil Defense and Disaster is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. George S. Palmer, of Leon.

Motion carried.

Report of Committee on Civil Defense and Disaster

J. ROCHER CHAPPELL, *Chairman*

Your chairman, shortly after appointment by the President of the Florida Medical Association, was appointed Florida State Deputy Director for Casualty Services by Governor Leroy Collins. This appointment was made on the recommendation of Dr. Wilson T. Sowder, State Health Officer, and Colonel H. W. Tarkington, State Civil Defense Director.

At the same time Dr. L. L. Parks, Jacksonville, Fla., was appointed Deputy Director for Public Health Services. The two of us assisted the State Civil Defense Office in drawing up survival plans for the State of Florida. Dr. Parks and I visited each of the six metropolitan target areas in Florida in an effort to assist the local chairmen in drawing up survival plans for their areas. We expect to visit again each of these metropolitan target areas sometime this year.

As State Deputy Medical Director for Casualty Services, your chairman attended a National Civil Defense meeting in New York on May 31, 1957, just preceding the meeting of the American Medical Association.

Your chairman also represented the Florida Medical Association at a meeting of the Committee on Civil Defense, Council on National Defense, American Medical Association, in Atlanta, Ga., on Oct. 5-6, 1957. This meeting was sponsored by the American Medical Association and was a regional meeting for the southeastern states.

Your chairman also attended a meeting in Chicago, Ill., on Nov. 9-10, 1957, sponsored by the American Medical Association for the benefit of state and county Civil Defense directors.

The state of Florida has, at the present time, nine 200-bed mobile Civil Defense Hospitals positioned over the state. We recommend that the number of these hospitals be increased tremendously. We believe there should be at least 50 or 60 in the state by this time next year. Local county commissioners, on the advice of their county medical directors, can obtain these hospitals from the Federal Government at no cost to the community. The only expense to the community would be a 2,500 cubic

foot trailer truck on which the entire hospital can be stored and made available for movement to any location at a moment's notice.

In conclusion, your committee would like to urge that all county medical directors perfect their plans of organization for the care of the sick and injured in case of a national disaster as soon as possible. We feel that time may be running out.

Dr. White: "The committee recommends approval of the Report on Medicare presented at the first meeting of the House of Delegates by Dr. John D. Milton, with commendation, and recommends that it be referred to the Board of Governors for study.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

Report on Medicare

JOHN D. MILTON, *Chairman*

At the called meeting of the House of Delegates on December 8, 1957, three representatives were appointed to renegotiate with the Office for Dependents' Medical Care, Drs. Burns A. Dobbins Jr., Donald F. Marion and John D. Milton.

On January 6-7, 1958 a new contract was negotiated in Washington, on substantially the same basis as the former contract, except for certain new items in medicine, acute emotional disorders, treatment of minor injuries and special procedures for rehabilitation.

During the period December 7, 1956 through March 31, 1958, Blue Shield, as our fiscal administrator, paid 24,758 claims for a total of $1,909,042.77. This represented almost 5 per cent of the entire amount spent for Medicare claims in the nation. In Florida, 1,981 physicians participated. Of these, 1,725 are members of the Association, 169 non-member M.D.'s and 87 practitioners of other healing arts. The average payment per doctor was $963.68.

It is interesting to note that during the same period of time, Blue Shield paid directly to physicians $172.50 for tissue examinations and $7,299.00 for radiological services.

Misunderstandings of the program have been mainly caused by:

1. Out-patient treatment which, with the exception of OB and bodily injuries, is not compensable under the program.
2. Out-patient diagnostic procedures which are not payable when they are in connection with admissions for medical care.
3. Out-patient accident cases, when the doctor always collects the first $15. If the patient is treated in the out-patient department of the hospital, charges for the full hospital bill are made by the hospital to the fiscal administrator of the hospital portion of the plan.

The Medicare Mediation Committees, county and state, have reviewed or are now reviewing a total of 1,483 cases referred by the fiscal administrator. This represents approximately 6 per cent of total claims received up to March 31, 1958.

All but one of our component county societies have appointed Medicare Mediation Committees. It will be helpful if these committees will:

1. Determine that the fees charged are those usual to the community.
2. Familiarize themselves with all phases of the Medicare program.
3. Attend meetings of the state committee whenever possible.
4. Assist the fiscal administrator and the state committee by handling claims promptly.
5. Assist in educating the membership of their respective societies.

It is recommended to the House of Delegates that necessary steps be taken to study the feasibility of directly contracting with the Office for Dependents' Medical Care for the Medicare Program with the Florida Medical Association being its own fiscal agent.

Dr. White: "Mr. President, I move the adoption of the entire report.

Seconded by Dr. Melvin M. Simmons, of Sarasota.

Motion carried.

Dr. White: "Mr. President, I would like to take this opportunity to thank the members of this committee, Drs. Edward W. Cullipher, Egbert V. Anderson, H. Phillip Hampton, and Donald F. Marion, and also thank you for appointing me."

Report of Reference Committee No. 4

Dr. Roberts: "Will the Chairman of Reference Committee No. 4, Dr. L. Washington Dowlen, please come forward and make his report?"

Dr. Dowlen: "Mr. President, Members of the House of Delegates:

"Your Reference Committee gave careful consideration to items referred to it and makes the following report:

"The Report of the Committee on Legislation and Public Policy and its supplement are approved.

"Mr. President, I move the adoption of this portion of the report.

Seconded by Dr. Simmons.

Motion carried.

Report of Committee on Legislation and Public Policy

H. PHILLIP HAMPTON, *Chairman*

Your Committee has worked actively during the past year in the formulation, promotion and maintenance of legislation in the best interest of scientific medicine and public health.

National Legislation

Special attention was given to our national legislative program and requests from the A.M.A. Committee on Legislation and the A.M.A. Washington Office to assist with specific legislation were complied with.

Our system of key contact physicians was revised this year to provide for a key physician and alternate key physician for each congressional district and for each senator.

Upon approval of the Board of Governors, the first annual meeting of F.M.A. officers and key contact physicians with Congressmen was held in Washington, D.C. on Jan. 28, 1958. Every congressional district in Florida was represented by physicians and a general discussion of pending and future legislation of interest to the medical profession was held with the Congressmen.

The F.M.A. officers and key contact physicians for Florida's Senators have scheduled a meeting with our Senators in Washington, D.C. for March 17, 1958.

Your Committee wishes to compliment the key contact physicians for their prompt action when called upon for assistance with national legislation.

State Legislation

The formulation and presentation of the program for the 1957 Session of the Florida Legislature was given in last year's report. The objectives of this program were:

1. Support the recommendations of Governor Leroy Collins to abolish the practice of naturopathy in Florida
2. Obtain an adequate appropriation for the Hospital Service for the Indigent program (Four million dollars), and
3. Discourage the passage of any health legislation deemed undesirable by the Association.

Your Committee is pleased to report that our Association fared well during the 1957 Session in all three phases.

For the first time since 1921, when naturopathy was originally recognized by the Legislature, we were able to curtail some of the statutory privileges of naturopaths. The amended Naturopathic Bill as it became law provided:

1. The Florida State Board of Naturopathic Examiners be abolished and all its powers be placed with the Florida State Board of Health.
2. The revocation of all licenses held by naturopaths who have not been in continuous practice in Florida for two years
3. All naturopaths practicing in Florida for two to fifteen years may continue to practice after recertification by the State Board of Health, but they are prohibited from prescribing or administering any drug or medicine included within materia medica or listed in the U.S. Pharmacopoeia
4. All naturopaths practicing in Florida for a period exceeding fifteen years may continue as in the past except they shall be permitted to administer directly narcotic drugs in cases of emergency but not to prescribe them.

The constitutionality of this law has been upheld by a circuit court and is now under consideration by the Florida Surpreme Court.

The full four million dollars requested for indigent hospitalization was appropriated and the hospitalization program of the State Department of Public Welfare for public assistance recipients was discontinued due to the fact no funds were appropriated.

Undesirable health legislation which became law was nominal. It was necessary to follow sixty-eight bills dealing directly or indirectly with medical legislation during the regular session.

Copies of specific medical bills considered and the voting record of legislators for the 1957 Session of the Florida Legislature may be obtained from our Executive Office.

Your Committee has worked actively toward coordination and liaison with governmental agencies to provide physician leadership regarding policies affecting medicine when they were being formulated, as opposed to combating adverse policies after their adoption.

Again your Committee would like to emphasize that the success or failure of our legislative program depends primarily upon work done at the local level by an informed membership developing better relations with legislators at home prior to the legislative session.

The Board of Governors approved a recommendation of your Committee to request Governor Leroy Collins to appoint a citizens medical committee on health in Florida composed primarily of physicians, to study the problem of the chronically ill and aged and other problems needing study.

On behalf of our Committee, I desire to express appreciation for the assistance rendered by officers, Board of Governors, members of the Association's executive office, our attorney, and the physicians of the county medical societies, without whose help our program would not have been successful.

Supplement

It is necessary to make a supplementary report from the Committee on Legislation and Public Policy because of recent events in legislation and government administration concerning medical care.

Officials of the F.M.A. and key contact men for our national legislators made two trips to Washington to confer with our Congressmen and Senators, administrators in the federal government, and members of the A.M.A. Washington office.

We learned that the Jenkins-Keogh bill to defer income tax on certain earned income paid into retirement funds was making progress but the prospects for its passage in this session of Congress will depend largely on the decision on whether to make tax cuts in general.

The Forand bill to provide hospital and surgical care for social security beneficiaries over 65 years of age is the most controversial medical bill in this congressional session and it now seems probable we will be spared its passage in this session of Congress by the grace of Sputnik.

Accompanied by members of the Washington office of the A.M.A. and representatives of the State and Territorial Health Officers, we met with the head of the Social Security Bureau and his legal and medical advisors to discuss the administration of federal funds available if matched by state funds for the payment of vendors of medical care to recipients of public welfare. The law requires that all funds to provide care for the indigent receiving aid under the four federal categories must be administered by a single state agency (State Welfare Board in Florida) but this agency may contract with other agencies or organizations for specific items of care. It was the administrators' considered opinion that medical care of the indigent should be considered a part of and coordinated with the total welfare program. We expressed the opinion that medical care of the indigent should be considered a part of and coordinated with the total medical care program for all of the citizens of this country.

In the 1957 session of the Florida Legislature a proposal to provide matching state funds to initiate the vendor medical payment plan for recipients of public welfare in Florida was not approved by the appropriations committee and instead a four million dollar state appropriation was made to the state-county fund to provide hospital care for the acutely ill indigent as recommended by the Board of Governors of the F.M.A. and Indigent Hospitalization Advisory Committee of the State Board of Health.

The Florida plan for providing hospital care for the acutely ill indigent is now functioning in sixty of the sixty-seven counties which have 98% of the population providing hospital care for about 1500 indigent a month at an average hospital stay of 9 to 10 days at $20 a day average hospital cost. Only one-third of these indigent patients were recipients of public welfare.

The State Welfare Board now has under consideration a plan to provide drugs for recipients of public welfare through the vendor payment program by means of a contract with the State Pharmaceutical Association. The cost of such a program would be difficult to estimate.

At the time of the 1959 session of the Florida Legislature there will be approximately $10,000,000 in federal funds available to be matched for providing medical care for recipients of public welfare under the vendor medical payment plan.

I cite you these related incidents so that you may draw your own conclusions.

A Committee on Health has just been appointed by Governor Collins upon the recommendation of the F.M.A.

to study problems in providing care for the indigent outside hospitals, medical care for patients with chronic disease and the aged, the activities of state and voluntary agencies providing medical care and other problems relating to the health of the citizens of Florida.

Perhaps from these studies we may gain factual information upon which we can base plans to meet these problems of medical care in the traditional manner of American medicine without further loss of individual freedom.

The Constituton and By-Laws of the Florida Medical Association now require a special meeting of the House of Delegates and Board of Governors with the Committee on Legislation and Public Policy to prepare a legislative program approximately one year prior to sessions of the Florida Legislature.

This has proved to be impractical and it is recommended that Chapter V, Section 1, Paragraph (57) of the Florida Medical Association Constitution and By-Laws—President Call Pre-Legislative Meeting—be deleted and an additional paragraph be substituted after Chapter VII, Section 4, Paragraph (72) as follows:

> "It shall be the duty of the Committee on Legislation and Public Policy to present state legislation which is to be sponsored or opposed by the Association to the First Meeting of the House of Delegates at its Annual Meeting the year preceding the convening of the Regular Session of the Florida Legislature. The policy of the Association regarding legislation between meetings of the House of Delegates shall be left to the discretion of the Committee on Legislation and Public Policy in consultation with the Board of Governors."

Dr. Dowlen: "The Report of the Committee on Mental Health is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. James T. Cook Jr.

Motion carried.

Report of Committee on Mental Health

SULLIVAN G. BEDELL, *Chairman*

Your Committee, since the last Annual Meeting, has worked toward its goal of placing the physicians of Florida in a position of leadership in working out the problems in the mental health field. The Florida Medical Association, through your Mental Health Committee, sponsored in September, 1957, a Mental Health Conference to which state leaders concerned with the problems were invited to present summaries of their organizations'activities and their plans for the future. Among the 24 attending were the chairman and members of the Interim Legislative Committee on Mental Health, the State Health Officer, directors of various state institutions and programs, the Dean of the University of Florida College of Medicine, and the Professor of Psychiatry at the University of Miami School of Medicine, and the Professor of Psychiatry at the University of Miami School of Medicine, as well as representatives from other organizations. The progress described in one year and the marked degree of cooperative effort demonstrate the soundness of the approach to the mental health problems in our state.

Your Chairman attended the Fourth Annual Meeting of the A.M.A. Council on Mental Health in Chicago in November, 1957, at which time the topics for discussion were:

1. The Role of the General Practitioner in Relation to the Specific Psychiatric Case
2. Blue Cross-Blue Shield Plans for the Psychiatric Patient
3. Relationship of the Psychiatrist in Private Practice to the General Hospital in His Community
4. Psychiatric and Related Mental Health Problems in Industry

Your Committee met in Jacksonville in September, 1957, and again in January, 1958, to re-evaluate the program and plan for its future activities. It was decided that a request would be made for a research grant to study and determine the most effective means to render outpatient psychiatric care and other mental health problems including a study of the need for institutional care for disturbed children.

Your Committee wishes to thank the officers and each individual member of the association for their cooperation in responding to the requests made of them in connection with the mental health program.

Dr. Dowlen: "The Report of the Committee on State Controlled Medical Institutions is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Anderson.

Motion carried.

Report of Committee on State Controlled Medical Institutions

WILLIAM D. ROGERS, *Chairman*

As chairman of the Committee on State Controlled Medical Institutions, I wish to submit a report covering the following institutions:

Florida State Hospital, Chattahoochee
G. Pierce Wood Memorial Hospital, Arcadia
South Florida State Hospital, Hollywood
Northeast Florida State Hospital, Macclenny
Sunland Training Center, Gainesville
Alcoholic Rehabilitation Center, Avon Park

During the past year your chairman has had occasion to visit each of these institutions and to obtain reports of their activities from the various superintendents.

The first four institutions listed above are under the Division of Mental Health, which was created by the legislature of 1957. A director has been appointed and now serves as a coordinator of these institutions, giving over-all administrative supervision.

The Florida State Hospital, Chattahoochee

The Florida State Hospital at the present time has 6,629 patients, having admitted during the past year roughly 2,500 patients, and has shown an over-all gain in population of only 16 during this year.The release rate has increased considerably due to improved treatment methods, additional staff members, and improvement in treatment facilities.

In addition to the treatment program within the hospital they have been able to add additional psychiatric social workers and have been carrying on a home placement program in that area. Also a program of follow-up care has been developed through the various County Health Units, which has contributed considerably in being able to carry on some therapy while the patients are on trial visits and release. The institution has also worked in close cooperation with the Vocational and Rehabilitation Service of the state, which has contributed to the release rate.

The Florida State Hospital still has quite a number of very old buildings which are beyond economic repair. However, a program is under way to gradually replace these facilities as early as time permits.

The G Pierce Wood Memorial Hospital, Arcadia

The G Pierce Wood Memorial Hospital, Arcadia, at present has a patient population of 1,650 with an ade-

quate staff and has been able to maintain a fairly high release rate. They have been somewhat hampered by lack of intensive treatment facilities and medical-surgical facilities but the legislature of 1957 has appropriated sufficient monies to construct a medical-surgical hospital and additional facilities for chronic diseases. There were also appropriated monies for an intensive treatment building, which is in the planning stage at present, however, construction will start at an early date.

The South Florida State Hospital, Hollywood

The South Florida State Hospital, Hollywood, is a completely new state mental hospital opened to receive patients March 1, 1957. At the present time they have 450 patients with a limited capacity of 484 beds.

However, the second stage of construction will be completed within the next few months, bringing capacity up to 1,060 patients. This institution is serving eight surrounding counties at present. They have an adequate staff and are developing a very fine program.

The Northeast Florida State Hospital, Macclenny

The Northeast Florida State Hospital, Macclenny, has not been opened to receive patients yet but is in the construction stage. It appears now that this institution will open during the spring of 1959.

With these additional facilities, and improvements and additions in existing hospitals, it is felt that we will have adequate facilities for the care of the mentally ill for some time.

However, I would like to point out that with the rapid growth of population in our state, which reflects in the admission rate, we can expect our admission rate to grow each year. In fact, the records indicate that in the last four years admissions in all Florida's state mental hospitals have grown from about 2,400 per year to about 3,600.

One of the greatest problems the mental hospitals are now confronted with is the large number of aged patients.

The Sunland Training Center at Gainesville

This institution was previously known as the Florida Farm Colony, the Legislature having changed the name to the Sunland Training Center at Gainesville during the last session of the legislature.

This institution has completed new facilities, which were made possible by the 1955 legislature; has expanded its bed capacity, and at the present time has slightly over 1,400 patients. There has also been an additional appropriation and planning to eventually bring this capacity up to 2,000 beds. However, even with the increased expansion at this institution there is still a waiting list of some 800 patients.

The legislature of 1957, however, did appropriate money to build a new Sunland Training Center in Lee County, which is under construction at the present time, and will relieve this tremendous waiting list a great deal.

The institution at Gainesville has continued to enlarge its professional staff. They now have three occupational therapists with a fourth to report in the near future. The training staff has also continued to develop and in addition to the Director of Training they have a Principal of Schools, and some eighteen teachers in that department. They have also set up a staff of Vocational Training personnel with four persons currently employed, a coordinator, one assistant coordinator and two Vocational Guidance Counselors. They are now beginning to make referrals to the State Vocational and Rehabilitation Service.

During the last year they have also been able to place their employees on a forty-four hour week, which required the additional employment of some 100 persons and brings their total of employees up to 800.

The Sunland Training Center has also continued their interest in research and this will expand as more staff is obtained.

The Florida Alcoholic Rehabilitation Program

During this past year the Florida Alcoholic Rehabilitation Program has continued to develop its services along the three main avenues of treatment, education and study. Treatment of alcoholism and rehabilitation of the alcoholic are offered by the program through four outpatient clinics located in Jacksonville, Miami, Pensacola, Tampa and through the 50 bed Alcoholic Rehabilitation Center opened in Avon Park in December, 1956.

The outpatient clinics, limited to ambulatory treatment, are headed by senior physicians who are psychiatrists. Since the opening of the clinics in 1955, 1310 individuals have been registered. Each clinic is staffed, in addition to the senior physician, by full-time psychiatric social workers, part-time internist and psychologist, and full-time clerical personnel.

The Alcoholic Rehabilitation Center, Avon Park, now slightly more than a year old, has admitted 479 patients. The staff of the Center consists of four part-time internists, two full-time psychologists, one full-time occupational therapist, two part-time laboratory technicians, one supervisor of nurses and aides, five registered nurses, eleven psychiatric aides, as well as the necessary dietary, housekeeping, maintenance and business personnel. The Center provides short term, intensive medical care for acute phases of alcoholism, as well as longer term care of 30 days for intensive psychotherapy as a part of the rehabilitation of alcoholics.

The statewide educational work of the Alcoholic Program has entered a new phase with the appointment of the Program's Educational Director in October, 1957. It is expected that this part of the State Program will increase in scope and activity.

Educational activities of the Program are limited to the subject of alcoholism and directed by Statute to the following groups: the general public, professional people who may be engaged in the treatment of alcholics, and chronic alcoholics. Activities now consist of speaking engagements, radio and television programs, distribution of films, community conferences, professional and in-service training, public meetings, and distribution of printed materials.

The Alcoholic Program has been directed by the State Legislature to undertake a careful study of the Chronic Drunkenness Offender in the state. It is expected that the Program will set up a contract with the University of Florida to carry out a multidisciplined study.

Dr. Dowlen: "The Report of the Poliomyelitis Medical Advisory Committee is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Fred Mathers.

Motion carried.

Report of
Poliomyelitis Medical Advisory Committee

RICHARD G. SKINNER JR., *Chairman*

The statewide polio immunization program instituted on March 1, 1957, was maintained to completion on June 30. The final success of the drive was hampered to a considerable extent by serious vaccine shortages in many areas of the state which developed early and continued in varying degrees throughout the period. These shortages necessitated a virtual halt to statewide promotional efforts.

In an attempt to evaluate the results of the program, a survey of the county medical societies was carried out in August. Questionnaires returned by 76 per cent of the societies were tabulated. In summary, the majority of the societies believed that the program had been worthwhile and that the primary reasons for the lack of complete success were (1) lack of vaccine and (2)

public apathy. A large number of societies indicated the need for continuing assistance by promoting polio immunization from the state level through all media of public information.

As a measure of the success of the immunization program, according to Florida State Board of Health statistics, 1,337,000 cc. of polio vaccine were shipped into the state from January 1 to June 30, 1957, as compared with 1,908,000 cc. shipped during the entire time prior to the period. The amount of commercial vaccine shipped during the first six months of 1957 was nearly double the cumulative amount shipped in the entire time prior to the period.

Constant efforts have been maintained to keep the county medical societies informed regarding policies and progress concerning polio.

Beginning in the summer of 1957, a series of meetings was held with representatives of the National Foundation for Infantile Paralysis in regard to a proposed evaluation survey of all polio patients needing further medical or rehabilitative assistance. In January, 1958, a suggested program for implementation of this activity was formulated by the Committee for presentation to the Board of Governors. Following approval, it was submitted to the NFIP for consideration. The cooperation of members of the Florida Medical Association in completing this survey was requested.

The Committee will continue to work through the executive office of the Association in promoting polio immunizations by private physicians and in keeping the membership informed regarding all matters of importance concerning polio.

Your chairman wishes to express appreciation to the officers and members of the Association, the members of the Committee, Drs. John J. Benton, Edward W. Cullipher, Frank H. Lindeman Jr., and George S. Palmer and the office staff of the Association for their willing response when called upon for assistance.

Dr. Dowlen: "The Resolutions—BB Guns To Be Declared Illegal—these resolutions are approved in principle and referred to the Committee on Legislation and Public Policy for study and action.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Herz.

Motion carried.

Resolution

BB Guns to Be Declared Illegal

WHEREAS, Each year brings an increasing number of eye injuries to children by use of BB guns; and

WHEREAS, The existing statutes are inadequate to control the unsupervised use of these weapons; and

WHEREAS, The Orange County Medical Society is interested in the conservation of vision as part of its public health program; therefore

BE IT RESOLVED, That the Orange County Medical Society approve the initiation of necessary measures by the Florida Medical Associatlon to make the possession or sale of BB guns or Air Rifles illegal in the State of Florida.

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to the Florida Medical Association.

Respectively submitted,
Robert W. Curry, *Secretary*
Orange County Medical Society

Resolution

BB Guns Illegal

WHEREAS: There is a yearly increase in the number of children who suffer eye injuries from accidents with BB guns

WHEREAS: There is an unrecorded number of eye injuries not amounting to total blindness, which number is to be counted additionally

WHEREAS: There is no training program in operation for these children

WHEREAS: The existing Florida Statute does not prevent these accidents

WHEREAS: The Orange County Medical Society and the Florida Society of Opthalmology and Otolaryngology have endorsed this resolution to declare illegal the sale or possession of BB guns or air rifles in the State of Florida and have recommended the Florida State Medical Society prepare steps necessary to have this enacted into law by the State Legislature.

THEREFORE BE IT RESOLVED: That the Florida State Medical Society endorse this resolution to make the sale and possession of BB guns or air rifles illegal in the State of Florida.

AND BE IT FURTHER RESOLVED: That the Florida State Medical Society prepare necessary steps and present this to the State Legislature for enactment into law.

Respectfully submitted,
Robert W. Curry, *Secretary*
Orange County Medical Society

Dr. Dowlen: "There were two resolutions on the Forand Bill. These resolutions are approved with the amendment that in the fourth paragraph of the resolution submitted by the Orange County Medical Society the words 'the best of' be deleted, so that the paragraph will read: 'WHEREAS, The old-age group is already receiving hospital and surgical care under existing programs; and'.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Robert E. Zellner.

Motion carried.

Resolution

Forand Bill

WHEREAS, The Forand Bill introduced in the last Congress proposes to amend the Social Security Act to provide hospital and surgical services for the 13 million Americans now receiving benefits under the old age and survivors retirement programs; and

WHEREAS, In order to finance these payments for present recipients, it would be necessary to increase the tax base for present wage earners from $4,200 to $6,000. And further it would be necessary to increase the employee and employers tax by 1 per cent at stated intervals until 1975 when the total Social Security tax on wages would be 9½ per cent and ad infinitum; and

WHEREAS, As of May 1957 the Social Security Administration had an unfunded obligation of 3 billion dollars with less than 1 billion dollars in its so-called Trust Fund. This is in addition to the 270 billions of the national debt. And further additions to the Social Security Program will only lead to national bankruptcy; and

WHEREAS, The old-age group is already receiving hospital and surgical care under existing programs; and

WHEREAS, When any person or a responsible member of his family is financially unable to pay for medical services, we pledge to continue to provide this service free of charge as individual physicians or through our local clinics or general hospitals; Therefore, Be It

RESOLVED, That the Orange County Medical Society go on record as opposed to the Forand Amendment to the Social Security Act as unnecessary and unsound fi-

nancially and one more step toward weakening our great Nation; and Be It Further

Resolved, That copies of this resolution be forwarded to all other county medical societies in Florida, to the administrators of each hospital in the Central Florida area, to all Florida members of the House of Representatives and Senators of these United States. And that it be presented to the House of Delegates of the Florida Medical Association for consideration and action.

Respectfully submitted,
Robert W. Curry, *Secretary*
Orange County Medical Society

Resolution

Opposing Forand Type Legislation

Your Board of Governors believes the Forand Bill (HR 9467) to be a dangerous and highly undesirable type of legislation and since the Association is already cooperating extensively with the American Medical Association to advise the public and the members of Congress of these dangers, it recommends approval of the following:

WHEREAS, Our American system of free competitive enterprise has produced the highest standards of health, high quality medical care and educational facilities, and

WHEREAS, National compulsory health insurance would constitute a distinct and radical departure from that system; therefore

BE IT RESOLVED, That the Florida Medical Association does hereby go on record against any Forand types of legislation (HR 9467) that would amend Title II of the Social Security Act by introducing a hospital and medical benefit thereby establishing a national system of compulsory health insurance.

Respectfully submitted,
Samuel M. Day, Secretary-Treasurer
Florida Medical Association

Dr. Dowlen: "The resolution on Replacing Interns within limitation of existing law is approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Alpheus T. Kennedy of Escambia.

Motion carried.

Resolution

Replacing Interns

WHEREAS, In many of the smaller approved hospitals in our state it is often impossible to replace interns within the limitation of the existing law, and whereas such situations can create a hazardous health problem in the local community,

THEREFORE, Be it resolved by the Escambia County Medical Society that the House of Delegates of the Florida Medical Association be requested to give serious consideration to a proposed amendment to Section 458.13 subparagraph (3) Florida Statutes 1957: add to end of next to the last sentence, "or unless for good cause an extension of time is granted by the Board to meet the health needs of the community or area served by an approved hospital."

Respectfully submitted,
Joseph Q. Perry, *Secretary*
Escambia County Medical Society

Dr. Dowlen: "The resolution on Optometry is approved with the amendment that subparagraph No. 2 be changed to read: 'That it reaffirm its position that it is unethical for its members to professionally associate voluntarily with optometrists.' This is the inclusion of the word 'professionally'.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Carl S. McLemore.

Motion carried.

Resolution

Optometry

Whereas, The function of optometry is to determine mechanical defects of the eye and to correct them by the prescription of proper lenses, and

Whereas, Optometrists are not qualified to do more than ascertain if mechanical defects exist and to correct them when necessary, and

Whereas, The Florida Statutes permit optometrists to diagnose and treat abnormal conditions of the human eye far beyond their qualifications and,

Whereas, Resolution No. 77, adopted by the House of Delegates of the American Medical Association in June 1955, provides that association between doctors of medicine and optometrists is unethical

Be it therefore resolved, That the Florida Society of Ophthalmology and Otolaryngology recommend to the Florida Medical Association:

1. That it promote legislation to restrict the statutory privileges of optometrists to the level of their qualifications, and the implementation be left to the discretion of the FMA Committee on Legislation and Public Policy in consultation with the officers of the Florida Society of Ophthalmology and Otolaryngology.
2. That it re-affirm its position that it is unethical for its members to professionally associate voluntarily with optometrists.

Respectfully submitted,
Marion W. Hester, Delegate
Polk County Medical Association

Dr. Dowlen: "The Resolution on Professional Liability Insurance is approved and it is recommended that it be referred to two committees: the Committee on Medical Economics and the Committee on Legislation and Public Policy.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Frank C. Bone, of Orange.

Motion carried.

Resolution

Professional Liability Insurance

WHEREAS, The annual professional liability insurance rates have increased two and one-half times in the past year for Florida physicians insured through the American Academy of Ophthalmology and Otolaryngology group insurors; and

WHEREAS, The administrators of that insurance state their experience shows their prior much lower insurance coverage rate to still be adequate; and

WHEREAS, Letters from the Florida State Insurance Commissioner and his Chief Auditor are conflicting as to the nature of the present Florida law governing insurance rates; and

WHEREAS, The present laws or their interpretation heavily financially penalize the Ophthalmologists and Otolaryngologists of Florida and apparently all members of the medical profession;

THEREFORE, BE IT RESOLVED, That the Florida Society of Ophthalmology and Otolaryngology is in favor of the Florida Medical Association exploring the restrictive nature and misunderstandings of the current laws govern-

ing professional liability insurance and taking such action as is deemed advisable in restoring competition in favor of more favorable professional liability insurance rates for the benefit of all members of the medical profession of the State of Florida.

Respectfully submitted,
Marion W. Hester, Delegate
Polk County Medical Association

Dr. Dowlen: "These are all new resolutions; if anyone desires to have them read I will do it. They were read at the first House of Delegates.

"The Resolution on Use of Experimental Animals is approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Holland.

Motion carried.

Resolution

Use of Experimental Animals

WHEREAS many of the most important advances in modern medicine and surgery have been made possible by the use of experimental animals; and

WHEREAS the devopment of insulin, modern chest and heart surgery are only a few of the advances in medical science developed by the use of experimental animals; and

WHEREAS modern research in accredited and approved research and teaching institutions involving experimental animals is conducted under entirely humane conditions; and

WHEREAS HR 10996 has been introduced in Congress and would prohibit interstate shipment of any dog or cat for medical or other scientific experimentation; and

WHEREAS enactment of HR 10996 would seriously inhibit the operation of many of America's medical research and teaching institutions and thus inevitably cost human lives,

NOW THEREFORE BE IT RESOLVED that the Dade County Medical Association strenuously urges Representative Oren Harris, Chairman of the House of Representatives Committee on Foreign and Interstate Commerce, and the Dade County and Florida representatives in the Senate and House of Representatives to oppose by all possible means, the passage of this proposed legislation.

Respectfully submitted,
George W. Robertson III, *Secretary*
Dade County Medical Association

Dr. Dowlen: "The Resolution on Compulsory Immunization of School Children is approved and it is recommended that it be referred to the Committee on Legislation and Public Policy.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

Resolution

Immunization

WHEREAS deaths from communicable diseases are relatively prevalent among children of school age; and

WHEREAS many of these diseases could be prevented by adequate inoculation against such diseases,

NOW THEREFORE BE IT RESOLVED that the Florida State Medical Association actively seek and support legislation requiring that all children in this state be required to present a certificate of inoculation against diphtheria, pertussis, tetanus, smallpox and poliomyelitis as a condition for admission to a public school; the only exception being bonafide objectors on the basis of religious or medical grounds.

Respectfully submitted,
George W. Robertson III, *Secretary*
Dade County Medical Association

Dr. Dowlen: "The recommendation of the Board of Governors to draft and sponsor legislation to permit group insurance coverage for members of Associations is approved.

"Mr. President, I move the adoption of this portion of the report."

Seconded by several delegates.

Motion carried.

Recommendation

That the Florida Medical Association through its Committee on Legislation and Public Policy in consultation with its Committee on Medical Economics draft and sponsor legislation to amend the Florida Statutes to permit group insurance coverage for members of Associations organized for other than group insurance purposes.

Dr. Dowlen: "Mr. President, I move the adoption of this entire report as amended."

Seconded by Dr. Kenneth A. Morris of Duval.

Motion carried.

Report of Reference Committee No. 5

Dr. Roberts: "I would like to ask Dr. Thomas C. Kenaston, Chairman of Reference Committee No. 5 to please come forward. I want to reiterate a little here—we don't want to have too much confusion and commotion. This is the last thing I want to get nailed down during my term as President—Blue Shield."

Dr. Kenaston: "Mr. President and Members of the House of Delegates:

"Open sessions were held by the Reference Committee on Blue Shield. The sessions were well attended with in excess of 100 members of the Florida Medical Association in attendance most of the time. Everyone who wished to speak before the committee was given an opportunity to do so without restriction and 31 physicians availed themselves of that opportunity.

"Your reference committee gave careful consideration to the items referred to it and makes the following report regarding the—

Recommendation of the Florida Medical Association Advisory Committee to Blue Shield Relative to New Contract (Committee of 17)

"1. We concur in the Committee of 17's recommendation that the membership of Florida Medical Association continue Blue Shield and give it every support necessary to keep it sucessful.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Simmons.

Motion carried.

"2. We further concur in the recommendation of the Committee of 17 that Blue Shield be requested to issue a contract which the committee of 17 has called Contract #II.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

"a. and b. While there was considerable discussion in the committee about the $6,000 income level, it was felt that the majority of the delegates appearing before the committee represented their societies as favoring the $5,000 income level for families and $3,600 for single people based on the conversion factor as outlined by the Committee of 17, and that, therefore, is our recommendation, even though we realize that with the changing economic situation the income level may have to be raised within the near future.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Patterson.

Motion carried.

"This committee further felt that this fee service limit not apply where the subscriber has indemnity policies other than catastrophic.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Simmons.

Motion carried.

"We concur in the following recommendations of the Committee of 17:

"c. That out-patient diagnostic x-rays be included in the body of the contract on a deductible basis using the schedule of fees hereto appended; that there be no deductible for accident cases and that a limit of $25.00 be set on these; that inclusion of radioisotope therapy of proven value be included on an Individual Consideration basis; that x-ray therapy for proven malignancies in-hospital, out-patient hospital, or in doctor's office be included.

"d. That surgery be covered including out-patient (minor) surgery as listed in the attached schedule. This is the Committee's decision after considering the requests of those who wished to omit out-patient services.

"e. That anesthesia coverage be allowed for on the basis of the California Relative Value Study (second edition, dated November 10, 1957) and that emergency room anesthesia (out-patient hospital) be included; such anesthesia to be allowed when administered by a physician not in charge of the case.

"f. That out-patient pathology of tissues on surgical cases for which Blue Shield has a liability for surgery be included in addition to in-patient pathology.

"g. That surgical assistant's fees be paid when indicated in cases with surgical fees over $100.00 similar to the Western New York Blue Shield Plan.

"h. That special pediatric care provisions be included as hereto appended.

"i. That provisions for concomitant care requiring proven needs be provided and that definite limits of liability be set.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Cook.

Someone asked: "Mr. President, do you have to buy the whole thing in one package?"

Dr. Roberts, "Can you answer that, Dr. Kenaston?"

Dr. Kenaston: "We had planned to vote on it, but if there is some particular part you would like to discuss, we can take that up separately if you wish."

Dr. James J. Hutson, of Dade, offered a substitute motion that each item be acted on separately.

Substitute motion seconded and lost.

Dr. Roberts: "Are there any discussions on Dr. Kenaston's motion?"

Motion carried.

Dr. Kenaston: "The committee recommends that paragraph j. of the Committee of 17 report dealing with consultations be given further study to prevent inequities.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Cook.

Motion carried.

"We concur in the following recommendations of the Committee of 17:

"k. That intensive medical care benefits be broadened as hereto appended and that the Blue Shield allowance be a per diem fee and that the intensive pay schedule replace for the first two days the per diem and scheduled diagnostic procedures not requiring another doctor's services or normal procedures usually accompanying care of such cases on intensive medical care.

"l. That delivery and post-partum care of the mother while in the hospital be the basis for the

maternity allowance. The same allowance should apply to out-of-hospital delivery and immediate post-partum care.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. McEwan.

Motion carried.

"The Committee especially emphasizes paragraphs 3 and 4 of the Committee of 17's recommendations, those paragraphs being as follows:

"3. After careful consideration we recommend that Blue Shield be requested to explore further the possibility of a prolonged illness contract or extended benefit contract to be presented if a new contract or contracts of a basic nature are approved and offered.

"4. We recommend that a study be made of the possibilities of a special category old age contract with low fee schedule and low service benefits.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. DeArmas.

Motion carried.

"We concur in the following recommendation of the Committee of 17:

"5. We recommendation that *Blue Cross* study the possibility of a deductible Blue Cross contract or contracts. This is suggested in response to numerous requests concerning deductible clauses. and it is felt that it is easier to control the deductible from the hospital point of view than from the doctor's point of view. Hospital deductible coverage should tend to control hospital admission for unneeded causes.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. John M. Butcher, of Sarasota.

Motion carried.

"The Committee stresses Section 6 of the Committee of 17's recommendations, urging the Board of Governors of the Florida Medical Association to set up a permanent committee to constantly revise not only Blue Shield fees but all related fees, the committee to be composed of representatives from *all* organized specialty societies, including General Practice, recognized by the Florida Medical Association.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Erasmus B. Hardee, of Indian River.

Motion carried.

"In reference to paragraph a. of Section 7 of the Committee of 17's recommendations, we recommend it not be adopted and not published in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Patterson.

Motion carried.

"We concur in the recommendation of the Committee of 17 contained in paragraph b. of Section 7, empowering the Board of Governors of the Florida Medical Association, upon the advice of the Committee of 17 and the correlation of information from all other working committees of F.M.A. involved, to act for the Association in recommending changes to Blue Shield.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. DeArmas.

Motion carried.

"It was felt by the Reference Committee that that portion of the Committee of 17's recommendations relative to a diagnostic x-ray rider (Section 8 of the recommendation) be further studied.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Fred Mathers.

Motion carried.

"We concur in the recommendation of the Committee of 17 (Section 9) that the present Blue Shield contract be maintained and that a study be made to make it equitable along the lines of the new contract proposed.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

"We further concur in the recommendation of the Committee of 17 (Section 10) that after contract problems have been worked out every means including a doctor's reference handbook based on that of the Massachusetts Medical Service be used to give the doctors intimate knowledge of their own Plan. Every means of informing every doctor in Florida should be used in an expansion of the Blue Shield method of giving information including a physician's relations department established in Blue Shield.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Butcher.

Motion carried.

"It was strongly felt by the Committee that some attention should be given to annual re-evaluation of subscriber income, but at this time

it does not seem realistic for Blue Shield to carry out such a procedure and it is recommended that each physician make his own determination, where possible.

"Mr. President, I move the adoption of this portion of the report, and the report as published in the Handbook."

Seconded by Dr. Thomley.

Motion carried.

Report of Advisory Committee to Blue Shield

HENRY J. BABERS JR., *Chairman*

The Committee has remained quite active in its study of Blue Shield problems this year. Committee members have given a great deal of their time and energy and have worked together in excellent harmony, which we hope will be to the benefit of the Association.

A long meeting was held on July 28, 1957. Following this, a day-long informational meeting was held in Jacksonville on Dec. 7, 1957. The report of this latter meeting has been published in the February, March and April issues of The Journal of the Florida Medical Association.

A comprehensive survey has been conducted and the results should be completed by the time of the Association's Annual Meeting in May.

A full committee meeting to study new contracts and to make recommendations for consideration by the House of Delegates was held on March 1-2. A report of these recommendations is to be presented as a supplementary report.

Recommendations
Advisory Committee to Blue Shield

1. This Committee recommends unanimously that the membership of Florida Medical Association continue Blue Shield and give it every support necessary to keep it successful. This is well worded by the Alachua County Medical Society resolution which was submitted to the Florida Medical Association in November of 1957.

2. After study of numerous contract proposals and study of contracts of other Plans and after thorough consideration of the multiple factors involved which include the numerous opinions from the various doctors in Florida and the various societies in Florida, we recommend to the House of Delegates of the Florida Medical Association that Blue Shield be requested to issue a contract which we have called contract #II and which is appended to these recommendations.

a. We recommend a service benefit contract with a level of $5,000 for a family and $3,600 for a single person based on conversion factors of 5/6 of a $6,000 proposal *across the board.*

b. Based on the California Relative Value Study, modified for Florida, we recommend that contract #II carry the conversion factors of $5.00 for surgery, $6.00 for medicine, $6.00 for consultants, $5.00 for pathology, $4.75 for anesthesia, $5.00 for obstetrics and $5.00 for pediatrics. Conversion factors for X-ray are to be developed from the radiological fee schedules submitted. (As the $5,000 service benefit was adopted, conversion factors will be 5/6th of those listed above).

c. That *out-patient* diagnostic X-rays be included in the body of the contract on a deductible basis using the schedule of fees hereto appended; that there be no deductible for accident cases and that a limit of $25.00 be set on these; that inclusion of radioisotope therapy of proven value be included on an Individual Consideration basis; that X-ray therapy for proven malignancies in-hospital, out-patient hospital, or in doctor's office be included.

d. That surgery be covered including out-patient (minor) surgery as listed in the attached schedule. This is the Committee's decision after considering the requests of those who wished to omit out-patient services.

e. That anesthesia coverage be allowed for on the basis of the California Relative Value Study (second edition, dated November 10, 1957) and that emergency room anesthesia (out-patient hospital) be included; such anesthesia to be allowed when administered by a physician not in charge of the case.

f. That out-patient pathology of tissues on surgical cases for which Blue Shield has a liability for surgery be included in addition to in-patient pathology.

g. That surgical assistant's fees be paid when indicated in cases with surgical fees over $100.00 similar to the Western New York Blue Shield Plan.

h. That special pediatric care provisions be included as hereto appended.

i. That provisions for concomitant care requiring proven needs be provided and that definite limits of liability be set.

j. That provision for consultations in hospital cases between doctors be given further study.

k. That intensive medical care benefits be broadened as hereto appendeed and that the Blue Shield allowance be a per diem fee and that the intensive pay schedule replace for the first two days the per diem and scheduled diagnostic procedures not requiring another doctor's services or normal procedures usually accompanying care of such cases on intensive medical care.

l. That delivery and post-partum care of the mother while in the hospital be the basis for the maternity allowance. The same allowance should apply to out of hospital delivery and immediate post-partum care.

3. After careful consideration we recommend that Blue Shield be requested to explore further the possibility of a prolonged illness contract or extended benefit contract to be presented if a new contract or contracts of a basic nature are approved and offered.

4. We recommend that a study be made of the posibilities of a special category old age contract with low fee schedule and low service benefits.

5. We recommend that *Blue Cross* study the possibility of a deductible Blue Cross contract or contracts. This is suggested in response to numerous requests concerning deductible clauses, and it is felt that it is easier to control the deductible from the hospital point of view than from the doctor's point of view. Hospital deductible coverage should tend to control hospital admission for unneeded causes.

6. The resolution of the Escambia County Medical Society which was referred to this Committee by the House of Delegates on May 8, 1957 was approved.

a. We recommend that *no fee schedule or service benefit level* be considered static and that re-appraisal every year or two years be mandatory.

b. We recommend strongly that a temporary committee on all fee schedules be developed by the FMA Board of Governors to function until such time as a revision in the Constitution and By-laws permits the setting up of a permanent committee (in reference to Blue Shield, the experience of the Massachusetts Medical Service will be helpful). This committee should consider *all* types of fee schedules and should work out further Florida modifications of the California Relative Value Study and should consult and confer with other committees of the Florida Medical Association in relation to fee schedules. This committee should consist of representatives of all organized specialty societies, including General Practice, recognized by FMA.

7. The resolution of the Broward County Medical Society referred to this Committee by the House of Delegates of the Florida Medical Association on May 8, 1957 was approved in principle and individual recommendations elsewhere in this report have been made on each point listed.

a. In reference to point 7, it is recommended that the Board of Governors of Florida Medical Association,

upon the advice of the Committee of 17 and the correlation of information from all other working committees of FMA involved, be empowered to act for the Association in recommending changes to Blue Shield.

8. It is recommended that study of an out-patient diagnostic x-ray rider and a general diagnostic rider be made for future use.

9. It is recommended that the present Blue Shield contract be maintained and that study be made to make it equitable along the lines of the new contract proposed.

10. It is recommended that after contract problems have been worked out every means including a doctor's reference handbook based on that of the Massachusetts Medical Service be used to give the doctors intimate knowledge of their own Plan. Every means of informing every doctor in Florida should be used in an expansion of the Blue Shield method of giving information including a physician's relations department established in Blue Shield.

Dr. Kenaston: "The resolution of the Marion County Medical Society relative to the Blue Shield Board of Directors as published in the handbook, the committee recommends that this resolution not be approved and not be published in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Zellner.

Motion carried.

"The resolution of the Dade County Medical Association relative to a $5,000 family income limit has been embodied in the recommendation of the Committee of 17 and we recommend its adoption.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

Resolution

$5,000 Income Limit

WHEREAS the Dade County Medical Association has reaffirmed its confidence in the ability of Blue Shield of Florida to provide the best type of prepaid medical care protection for the citizens of our state, and

WHEREAS the Dade County Medical Association has requested Blue Shield of Florida to prepare revised contracts so that full service benefits will be available to a greater percentage of Blue Shield subscribers,

NOW THEREFORE BE IT RESOLVED that the Dade County Medical Association approve in principle the newly proposed Florida Blue Shield contract, and

BE IT FURTHER RESOLVED that the Dade County Medical Association believes that the premiums are not practicable at the $6,000.00 family income limit and therefore recommends that the contracts be approved at the $5,000.00 family income limit and that the premiums be further reduced in accordance with other resolutions submitted by this association.

Respectfully submitted,
George W. Robertson III, *Secretary*
Dade County Medical Association

Dr. Kenaston: "The resolution of the Broward County Medical Association approving the $6,000 income limitation has been covered in the recommendation of the Committee of 17 and we recommend that it not be approved and not be published in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Seconded and carried.

"The resolution of the Dade County Medical Association relative to the exclusion of surgical assistant's fees from the Blue Shield, the committee recommends that this resolution not be adopted and not be published in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Butcher.

Motion carried by a standing vote.

"The resolution of the Dade County Medical Association relative to co-insurance for out-patient benefits in surgery, pathology, radiology and anesthesia, the committee recommends that this resolution not be approved and not be published in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Mathers.

Motion carried.

"The committee recommends the approval of the resolution of the Broward Medical Association commending the Committee of 17 and its chairman, Dr. Henry J. Babers Jr.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Burns A. Dobbins Jr. of Broward.

Dr. Kenaston read the resolution.

Dr. Dobbins asked permission to show a slide listing the members of this committee.

Motion carried.

Resolution

Commendation

WHEREAS the Blue Shield Liaison Committee of the Florida Medical Association known as the "Committee of 17" has done such a diligent and thorough piece of work in studying the fee schedule of Blue Shield;

BE IT RESOLVED that regardless of the action of the Florida Medical Association or Blue Shield in accepting these proposals, a special commendation be awarded chairman Henry Babers and his entire committee for such an untiring and excellent study.

Submitted by the Broward County Medical Association.

Respectfully submitted,
Garland M. Johnson, *Secretary*
Broward County Medical Association

Dr. Kenaston: "Mr. President, I move the adoption of this entire report."

Seconded by Dr. S. Carnes Harvard.

The Chair recognized Dr. Chas. J. Collins, of Orange.

Dr. Collins: "I have been asked to come up and speak a few words for the minority of the Orange County delegation who came to this meeting opposed to this plan. We still hope to be convinced of the wisdom of it and we are perfectly willing to accept it with an open mind. We attended the hearing of Dr. Kenaston's Reference Committee, we were given our say, and we wish to commend Dr. Kenaston's committee for the impartial manner in which this hearing was conducted. We also wish to commend Dr. Babers and his committee, of which our own Bob Zellner was a member, for their exhaustive study. We feel that if this plan is to work, it must have the wholehearted support of the doctors of Florida. In the event that this report as a whole is adopted, and it seems very likely that it will be, the members of the Orange County delegation who were opposed in the beginning to this report, pledge their wholehearted cooperation and say that they will do everything within their power to make this plan work."

The Chair recognized Dr. Russell B. Carson, President of Blue Shield.

Dr. Carson: "Speaking for the Board of Blue Shield, I wish to thank the Committee of 17 and I wish to say humbly, thanks for the spirit of cooperation and the actions that the House of Delegates has shown this morning to the efforts of your Blue Shield. I would like to underline and italicize "your Blue Shield." Your Board is going to keep it your Blue Shield as long as you keep electing men from this body. I pledge you that when you do not feel that we are your Blue Shield, you should get rid of us. Thank you very much."

The Chair recognized Dr. David R. Murphey Jr., of Hillsborough.

Dr. Murphey: "Mr. President, Members of the House of Delegates:

"I appear before you as Chairman of the Hillsborough County delegation. I appeared before and spoke before the Reference Committee as an individual. Our delegation from Hillsborough County came instructed. After I spoke as an individual, we caucused. When I spoke as an individual, I pledged my wholehearted support to whatever you did, as an individual. After our caucus, there was some question as to whether we were allowed to change our instructions; the majority thought we should change and we changed to support what has been recommended, and I appeared before the committee as chairman of the Hillsborough County delegation. I am certain that the doctors of Hillsborough County will do the best they can to support what you have passed."

The Chair recognized Dr. Ralph Herz, of Monroe.

Dr. Hertz: "Mr. Chairman, Members of the House of Delegates:

"In addition to the commendation you have given the Committee of 17, I move that this House of Delegates instruct the Secretary of the F.M.A. to have a Certificate of Merit engraved suitable for framing and suitably worded, to express our appreciation for the work they have done for the past two years; that these certificates be signed by the President and Secretary of the Association and bear the seal of the Florida Medical Association."

Dr. Roberts: "I will have to rule that the doctor's motion is out of order because we have a motion before the House. It is his privilege, I understand, to make it a substitute motion if he wishes."

Dr. Herz: "I will withdraw this motion and make it at a later time."

Dr. John D. Milton, of Dade, was recognized.

Dr. Milton: "I am heartily in favor and am very happy over the recommendations of this committee. There is just one thing that I would like to bring out and I would like the House of Delegates to realize. On the $5,000 income level, with the recommendations of the Committee of 17, you bring down the conversion factor to less than that of Medicare today. . Medicare is on a $4,500 income level and I am just afraid that government later in our negotiations will say that the men of the Florida Medical Association have approved a conversion factor on the California Relative Value Fee Schedule that is less than ours, therefore, since we are on a lower income level, we feel that you should take Medicare on a fee comparable to what this contract will be. I just want you to keep this in mind in further deliberations, that possibly it should be brought up to the 4.5 conversion factor."

The Chair recognized Dr. Robert E. Zellner, of Orange.

Dr. Zellner: "In reference to Dr. Milton's report, that's a misconception, Dr. Milton. The Medicare ceiling income is $22,000, not $5,000, because $22,000 is the salary of a general. This is a $5,000 ceiling. Whereas Medicare states that the average income is $4,200, under this $5,000 ceiling, the average income would be somewhere less than that, about $3,800 or $3,900, so I think

we can certainly answer the Medicare people by pointing to the upper limit of what the General makes as opposed to the $5,000 limit.

"While I am on my feet, I would like to say something with reference to the motion which was withdrawn. I want to say this as a member of the Committee of 17. We deeply appreciate all the laudatory remarks, but I think it is establishing a bad precedent to give one of the committees a scroll. I would like to point to the work of Dr. Hampton and especially to the work of Dr. Milton on Medicare, and I can assure you that nothing that we have done has in any way contributed more to the Association than countless other committee members. It is enough to get our backs scratched a little and we appreciate your good thoughts and good will."

The Chair recognized Dr. Herbert L. Bryans, of Escambia.

Dr. Bryans: "Mr. President, Gentlemen of the House:

"In view of what Dr. Milton has just said in reference to Medicare, I would like to amend the motion of approving the report of the Reference Committee as a whole and ask for reconsideration on that one section, dealing with the $5,000 and $6,000 clause."

Seconded by Dr. Egbert V. Anderson, of Pensacola.

Dr. Donald F. Marion of Dade, asked to discuss the motion to amend.

Dr. Marion: "I will be very brief, gentlemen. I would like to say in defense of Dr. Milton's wise remarks, as things appear to be, as things technically are, we do negotiate with the authorities in Washington for Medicare fees. I do not wish to make any rash statements and I hope my words will be understood, I did gain the impression, right or wrong, and I could easily be wrong, when I was given the opportunity to go along with John to observe the machinery of negotiations in Washington, that even though what Dr. Milton has warned us should be taken very seriously, even though any fee schedule we agree to in Workman's Compensation or Blue Shield or any other aspect of service that requires an agreement on a fee schedule, it is dynamite. We all know it is. We all deplore it. The point I am making is this—it is true that it may be seized upon as an excuse and as a justification for lowering Medicare fees, but please, gentlemen, think with me, and agree with me or not as you see fit, whenever the Federal Government wishes to lower Medicare fees, they are going to lower them anyway and I don't believe that should be taken into consideration in our deliberations about Blue Shield today."

Dr. Roberts: "Are there any other discussions on the amendment."

Dr. Milton: "I am against the amendment."

On voice vote, the amendment failed.

Dr. Roberts asked for a voice vote on Dr. Kenaston's original motion to approve the entire report.

Motion carried.

Dr. Hertz: "May I now make my motion? I would like to add the names of Dr. Milton and Dr. Hampton."

There was no answer to Dr. Roberts request for a second to the motion.

Dr. Roberts: "I am sorry, doctor. It was a noble gesture."

The Chair recognized Dr. Samuel M. Day.

Dr. Day: "Two of our Past Presidents are ill and unable to be here, and I would like permission or direction of this group to send them a telegram and give them our best wishes. They are Dr. Ross and Dr. Waas of Jacksonville."

One of the delegates advised that Dr. J. C. Vinson of Fort Myers was also ill.

Dr. Bryans: "I move that Dr. Day be instructed to send them a telegram."

Seconded by Dr. Herz.

Motion carried unanimously.

Dr. Roberts: "At this time, we are ready for any other unfinished business."

Dr. Ashbel C. Williams: "Mr. President, because of the rather urgent nature of this business, I would like to move that the rules be suspended which require that all resolutions presented to the House of Delegates be referred to a Reference Committee of the House of Delegates before final action is taken, in order to present a resolution with reference to the Annual Dinner. I so move."

Seconded by Dr. Bryans.

Motion carried.

Dr. Williams read the Resolution on Annual Dinner.

Dr. Williams: "I move the adoption of this resolution."

Seconded by Dr. Hardee.

Motion carried.

Resolution

Annual Dinner

WHEREAS, although the 1957 House of Delegates voted to continue the Annual Dinner after it had been

temporarily discontinued, the attendance at the 1958 Dinner was far below expectations,

WHEREAS, this has created a serious problem for the Association and the hotel in attempting to make adequate and satisfactory preparations,

WHEREAS, it is anticipated that convention hotels will require a firm commitment and guarantee for future dinners which could result in a heavy financial loss to the Association,

THEREFORE BE IT RESOLVED, that the advisability of having a dinner at each annual meeting be left to the discretion of the Board of Governors.

Ashbel C. Williams, *Delegate*
Duval County Medical Society

Dr. Roberts: "Under unfinished business, I want to ask again—we did it at the dinner last night—Dr. Meriwether and Dr. Andrews tied for the Duval Cup for the low net score. Dr. Henley and Dr. Bryant tied for the low gross, which I understand is the Orlando Cup. Now, if any of those golf players are here, something has to be done about it. This is one time the Chair is not going to rule on who is the winner."

Dr. Murphey: "Dr. Meriwether had to go home. He left me to either bring it to him or match for it."

Dr. Holland: "Dr. Andrews left me to get it if he won; he didn't say anything about matching for it."

Dr. McEwan: "I move we have a public matching tournament here."

Seconded by Dr. Butcher.

Motion carried.

Dr. Roberts: "Dr. Murphey and Dr. Holland, please come before the rostrum."

Dr. Holland and Dr. Murphey flipped coins; Dr. Holland matched Dr. Murphey and won the cup for Dr. Andrews.

Since neither Dr. Henley nor Dr. Bryant were present, Dr. Roberts ruled that the tie would have to be settled later.

Dr. Roberts: "I want to ask Dr. Julian Rickles, Chairman of the Golf Committee, if he is here, or if there is anybody from Miami who will give him the message, I would like that committee to decide on the tie between Drs. Henley and Bryant."

Dr. Rowland E. Wood: "I move that we suspend the rules to hold the election of officers at this time."

Seconded by Dr. Patterson.

Motion carried.

Dr. Roberts: "Every year, at high noon, at the end of the Florida Medical Association convention, a very important event takes place. The Chair now would like to recognize anyone who wishes to make a nomination for President-Elect."

Dr. S. Carnes Harvard, of Pasco: "Dr. Roberts, Members of the House of Delegates, Members of the Florida Medical Association and Guests:

"It is seldom that a delegate from a society in your organization that has only one vote has the honor to nominate a man for your highest office —the Presidency.

"I, therefore, consider it a great privilege indeed to nominate Dr. Ralph W. Jack of Miami for the office of President of the Florida Medical Association.

"Dr. Jack is a graduate of Yale University with a BS degree in 1926. He received his medical degree from Johns Hopkins University in 1930. Following his graduation he interned at Johns Hopkins from 1930 to 1932. He also completed his residency at Johns Hopkins from 1932 to 1936 in Obstetrics, Gynecology and Pathology.

"Following his residency he came to Miami, Florida to practice obstetrics and gynecology, where he has been ever since except to serve in the navy during World War II. He has been on the staffs and Chief of Obstetrics and Gynecology in various hospitals in Miami.

"During the war he was a Commander in the Navy and served with distinction receiving a Navy Unit Citation as amphibious combat surgeon at Iwo Jima and Okinawa.

"He has held several offices in your state organization and has always filled them well in a modest and capable manner. He is your immediate retiring First Vice President. Dr. Jack was Chairman of the Council in 1955 and was also Chairman of the Credentials Committee from 1954 to 1958. In 1954 he was Chairman of the Program Committee, AMA Clinic Session. Whatever he has been called on to do for you, he has always done well and without ostentation.

"Not only is he a member of your organization, but he also belongs to the American Medical Association, Southern Medical Association, American College of Surgeons, Southeastern Surgical Congress, South Atlantic Association of Obstetrics and Gynecology and others too numerous to mention. Suffice it to say that in all these organizations, he has served well and to the best of his ability whenever he was called upon. I could go on listing to you Dr. Jack's many qualifications, but I know all of you are as anxious to get home as I am. Let me say this to you in closing my nomination—that I have known Ralph Jack personally for several years, know the

stock he comes from and I am sure that he will guide you honestly, safely and well if elected to the Presidency."

There being no other nominations, Dr. Eugene B. Maxwell of Hillsborough moved that nominations be closed.

Dr. Bryans: "I would like to second that and add that the secretary be instructed to cast a unanimous vote for Dr. Ralph Jack."

Motion carried.

Dr. John D. Milton and Dr. Walter W. Sackett Jr. escorted Dr. Jack to the rostrum.

Dr. Jack: "Mr. President, Members of the House of Delegates, Members of the Florida Medical Association and Guests:

"For many years, I have set out there as the President and a number of the Past Presidents were in the spot that I find myself in this minute. I remember each one of them talking about how scared he was, and I know what they were talking about. Dr. Roberts well illustrated how scared he was with a story. I won't compete with that story. I remember Dr. Annis said he was scared. Dr. Langley was scared. Dr. Milton was scared until last night. I believe the only one I can remember who did not say he was scared was Bob McIver, so I have to believe that all of them were telling the truth. I know it now. I will add, however, that I find myself somewhat bewildered, as well as scared. If any of you has ever graduated from Yale University and found anything with the name, Harvard, talking about you as I just heard, you will find yourself plenty bewildered.

"Gentlemen and ladies, it is with all humility that I accept election to this office. I only hope through the coming two years that I will be able to carry out the duties of the office to which you have elected me in a way that will always be to your satisfaction. I recognize that you have bestowed on me the highest honor at your command. I hope to fulfill it in every sincere way I know how."

Dr. Roberts: "Do I hear a nomination for First Vice President?"

Dr. Franklin Evans, of Dade: "Mr. President, Delegates and Guests:

"Dr. Harvard in nominating Dr. Jack made reference to the fact that it was a privilege for a single member of a delegation to nominate a delegate from a large delegation. I am going to reverse that and be the member of a large delegation to nominate the single member. This might sound a little like log rolling, but it really isn't.

"I would like to say that it is indeed a privilege and a pleasure to be able to nominate this gentleman to the office of First Vice President. He is well known certainly to most of you for the years he has served in this House. He has served the Association well and certainly merits recognition for it. This particular gentlemen is a graduate of Emory University in 1930 and has practiced in a small town in Florida for the past 25 to 30 years, and during all of this time he has been in and out of this House of Delegates for these many years. There is no need to list his qualifications or the various organizations he is a member of, because of the fact that he is known to you. I would like to point out two offices which he has held which certainly indicate the esteem in which he is held by his fellow physicians. No. 1, as a general practitioner, he is a past president of the Florida Society of Obstetrics and Gynecology, and I, personally, as a general practitioner think that is a high honor; the other, he is immediate past Chairman of the Florida Medical Association's Council. Therefore, without further ado, I would like to place in nomination for the office of First Vice President, the delegate from the Pasco-Hernando-Citrus County Medical Society, Dr. S. Carnes Harvard."

There being no other nominations, Dr. Chas. J. Collins moved that nominations be closed and the secretary cast a unanimous ballot for Dr. Harvard.

Motion seconded and carried.

The Chair asked for nominations for Second Vice President.

Dr. Sidney G .Kennedy Jr., of Escambia: "Mr. President, Members of the House of Delegates:

"It is a pleasure for me to place in nomination for the office of Second Vice President of the Florida Medical Association, Dr. Joseph W. Douglas, of Pensacola, a member of this delegation and a member of the Escambia County delegation. He is an honored and distinguished member of the Escambia County Medical Society and he has served us well. He is now President of the Escambia County Medical Society and is also President of the Florida Society of Obstetrics and Gynecology. It gives me great pleasure at this time to place in nomination for the office of Second Vice President, Dr. Douglas."

Dr. Elmer B. Campbell Sr., of Pinellas: "Mr. President, Members of the House of Delegates:

"I would like to bring to your attention a gentleman whom I think needs little reference to

his past record in the support of this organization, whose scientific background and whose political background especially fits him for the high position of Second Vice President of the Florida Medical Association. I would like to nominate Dr. Walter E. Murphree, of Gainesville."

Dr. Herz moved that nominations be closed.

Seconded by Dr. Sias.

Motion carried.

Dr. Roberts asked Drs. Thomley, Bowen and Butcher to serve as tellers.

Dr. Zellner moved that the rules be suspended and that the election of other officers continue while awaiting the results of the ballot.

Seconded and carried.

Dr. Roberts: "May I have nominations for Third Vice President?"

Dr. McEwan: "I nominate the loser of the present election."

Dr. Milton called attention to the fact that Dr. Murphree is the incumbent.

On motion duly made, seconded and carried, the loser of the election for Second Vice President was elected Third Vice President.

Dr. Roberts: "The Chair wishes to hear nominations for Secretary-Treasurer."

Dr. Sackett: "Members of the House of Delegates, Visitors, Mr. President:

"Would I had the flowing white coat of one of the previous nominators for this office or the audacity to take off my coat as one of my predecessors did, but I am afraid there might be a hole in my shirt, but I rise to nominate a man whom I first met as he came up to the University of Alabama from the cotton patches of Alexander City—you can still tell it. This man has served us well in the capacity of Secretary-Treasurer and I give you our perennial Secretary-Treasurer, Sam Day."

Dr. Steward: "I move that nominations be closed and a unanimous ballot be cast for Dr. Day."

Seconded and carried.

The Chair called for nominations for Editor of The Journal.

Dr. Cullipher: "Mr. President, Members of the House:

"In the words of one of our better known men, all I ask of this Association is the privilege of coming every year, wearing a coat, tie, keeping the hair out of my eyes and offering in nomination the name of my good friend, your friend, Dr. Shaler Richardson."

Dr. Charles McD. Harris Jr. moved that nominations be closed, and that a unanimous ballot be cast for Dr. Richardson.

Seconded and carried.

Dr. Roberts: "You have almost elected a slate, when we get the information for this second position, we will be able to give you more information about who the officers are."

Dr. Butcher as Chairman of Tellers announced that Dr. Murphee was elected as Second Vice President. The vote was 69 for Dr. Murphree, 54 for Dr. Douglas.

Dr. Roberts: "It is just going to be a short while before you are going to have a real President of the Florida Medical Association. I want to say this before he gets here. I have been closely associated with Dr. Annis for the last two or three years in F.M.A. affairs. I love the Florida Medical Association so much I hate to turn it over, but since I know who is going to be your President, I also know that it will be in good hands. I could speak and speak about Jere, but you know Jere like I know Jere, so without any hestitation, I can hand the affairs of the Florida Medical Association over to Dr. Jere Annis without apology and right now with a lot of enthusiasm.

"I want to ask Dr. Herman Watson and Dr. Edward Jelks to escort Dr. Annis to the rostrum and I want to further ask the man who nominated Dr. Annis when he was elected to follow along with this group to be sure that he gets here and gets here safely, Dr. Boulware.

"Jere, without a lot of pomp and ceremony, I have a very short message to give you. You are going to have trouble. You are gong to have a lot of fun. You are going to meet more friends, you will perhaps lose a friend or two, but I know you have courage and I know you go strictly according to your convictions, so I want to give you your personal gavel to preside over the Florida Medical Association for this year. And I want to give you also, a little slogan from past experience—now that you have gavel, you will travel.

"I also want to present to you a pretty worn out bag. It will carry your lunch, it will carry refreshments; it will carry one dirty shirt, and to make you really, officially the President of the Florida Medical Association, I want you to get this grip so you will be 'with portfolio.'

"Members of the House of Delegates, and Guests, may I present to you the President of the Florida Medical Association, Dr. Jere Annis."

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

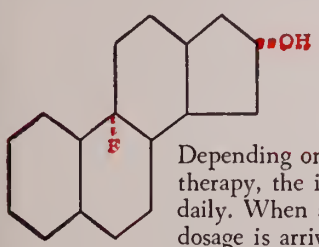
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13. Dubois, E. L.: Personal Communication.

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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

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Dr. Annis: "I feel as I know many others have when they stood here that perhaps you sent a boy to do a man's job. I just hope that he isn't too small a boy. I will try to grow into the job. This is commencement time and we are going to graduate our leading scholar, our star pupil, your Past President Bill Roberts. You know him, he has been a friend of yours this last year and has come to be a part of the Florida Medical Association and a part of the heart of each one of us. Again, without ado, I would like to give him his diploma as a doctor of humanities, if you will, and to graduate him summa cum laude.

"With that, his class pin, and congratulate him, for myself and for all of you I know, on having made us a fine president this last year and to remind him again that we are just graduating him here today so that he can keep on with his postgraduate work. Sit down, now Bill, don't move away from that Chair, because when I turn around and say, what do we do now? I want you right there.

"We have one announcement. The Board of Governors will meet, the new Board, immediately after this in the Caribbean Room for our post-convention meeting. If Dr. Homer Pearson will come forward and pronounce the benediction at the end of that benediction and at the sound of the gavel, this Eighty-Fourth Annual Meeting of the Florida Medical Association will stand adjourned."

The assembly rose for the benediction.

Dr. Pearson: "May the love of God, the love of Jesus Christ, Our Lord, and the Communion of the Holy Spirit be with you now and forevermore. Amen."

Scientific Assemblies

The First Scientific Assembly convened at 9:30 a.m., Tuesday, May 13, in the Bal Masque Room of the Americana Hotel with Drs. George T. Harrell Jr. of Gainesville and Richard Reeser Jr. of St. Petersburg presiding. The following papers were read and discussed:

"Hearing Loss in Persons of Advanced Age," Abraham R. Hollender and Otto S. Blum, Miami Beach. Presented by Dr. Hollender.

"An Analysis of the Causes of Blindness in Florida," Nathan S. Rubin, Pensacola.

"False Positive Pregnancy Tests Caused by Sparine and Thorazine," Gerard H. Hilbert, Pensacola.

"Reversal of Intractable Cardiac Edema," David A. Newman, Palm Beach.

"The Use of Carbon Dioxide in the Treatment of Postconcussion Syndromes," Michael M. Gilbert, Miami.

"The Value of Bone Marrow Examination in the Diagnosis of Malignant Disease," Robert G. Cushman, Jacksonville.

The Second Scientific Assembly convened at 2:00 p.m., Tuesday, May 13, in the Bal Masque Room of the Americana Hotel with Drs. Donald F. Marion of Miami and Franz H. Stewart of Miami presiding. The following papers were read and discussed:

"Physiologic Basis for Ulcer Surgery," Edward R. Woodward, Gainesville.

"Ventricular Aneurysm," Richard G. Connar, Tampa.

"Differential Diagnoses of Pulmonary Tuberculosis," George H. Hames and Maurice Kovnat, Lantana. Presented by Dr. Hames.

"Office and Bedside Evaluation of Pulmonary Function," William W. Stead, Gainesville.

"Surgery in the Relief of Dyspnea of Ventilatory Origin," John G. Chesney, DeWitt C. Daughtry and Harold C. Spear, Miami. Presented by Dr. Chesney.

"Pulmonary Surgery in Infants and Children," Hawley H. Seiler, Tampa.

Registration

The total registration for the 84th annual meeting at Bal Harbour was 1,986. The registrants include 937 members of the Association, 158 visiting physicians, 120 other guests, 403 members and guests of the Woman's Auxiliary, 72 scientific exhibitors and 296 representatives of exhibiting firms. There were 21 other states and 3 foreign countries represented.

Registration List

OFFICERS

William C. Roberts, M.D., President ..... Panama City
Jere W. Annis, M.D., President-Elect ..... Lakeland
Ralph W. Jack, M.D., 1st Vice President ..... Miami
Walter E. Murphree, M.D.,
2nd Vice President ..... Gainesville
James T. Cook Jr., M.D., 3rd Vice President ..... Marianna
Samuel M. Day, M.D., Secretary-Treasurer ..... Jacksonville
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ANNUAL JOINT REPORT

Secretary-Treasurer, Samuel, M. Day, M.D.
Managing Director, Ernest R. Gibson

This report covers the administrative year of 1957-1958 and is submitted as a brief summarization of many and varied activities of the executive office during this period.

The financial status of the Association is shown in the audited statement at the end of this report.

PUBLICATIONS

Assigned duties of the Department of Publications include publishing The Journal, the Florida Medical Directory, House of Delegates Handbook, programs for the Annual and District Meetings; preparation and distribution of the newsletter "Brief", multilithing, and the mailing of the quarterly Journal of the Florida Academy of General Practice.

Supervising the Department is Mr. Tom Jarvis who also serves as Assistant Managing Editor of The Journal. Assisting is Mrs. Louise Rader, Journal Technician. Mrs. Edith B. Hill is Editorial Consultant for The Journal.

The Journal

During this fiscal year, 42,670 copies of The Journal were printed, an increase of 2,195 over the previous year. Expenses amounted to $40,621.81 and income to $55,097.69. Included in expenses are paper, printing, engraving, postage, drayage and other items necessary to production. In income is listed revenue from advertising, paid subscribers, non-member reprints, and the allocation of subscriptions from dues paid by members.

The salaries of employees of the Department are not included in the expenses of The Journal, since publishing The Journal is not their only activity.

There was an increase in printing cost this year, however, this increase is being partially offset by the use of a different grade of paper and by buying paper in larger quantities.

Florida Medical Directory

Production cost of 4,700 copies of the 1958 Florida Medical Directory was $2,927.78. Revenue from advertising and miscellaneous sales at $2 per copy amounted to $3,315.00. Each member has been sent a copy.

Copy for the rosters is provided by the Administration Department, with the Publication Department responsible for other copy and actual production.

House of Delegates Handbook

This Department is responsible for production of the Handbook of the House of Delegates. Reports from the various Association committees and the list of delegates and alternates are provided by Administration. The agenda for meetings of the House is prepared by the Department in consultation with the Managing Director.

Programs

Type used for The Journal is utilized by the Department in production of programs for the Annual Meeting. The programs for the Medical District Meetings are also produced by the Department; copy being prepared in the Department under supervision of the Managing Director.

Briefs

The Department has printed and mailed 13 issues of Briefs this year. Copy is not always prepared by this Department. Information currently valuable to members may be obtained from the Managing Director or the Supervisor of the Bureau of Public Relations.

Multilithing

Small printing jobs from all departments were handled by employees of this Department. These included forms, record cards, reports, booklets, letterhead, letters, news releases, and in addition, the Yearbook of the Woman's Auxiliary to the Florida Medical Association.

Journal of the Florida Academy of General Practice

Employees of this Department distribute quarterly the Journal of the Florida Academy of General Practice using the Association's mailing facilities. Requested by the Academy, this service is provided at an agreed rate of two cents per copy.

PUBLIC RELATIONS

Programs

The public relations and legislative programs of the Florida Medical Association, as implemented by the Assistant Managing Director and the Bureau of Public Relations, are determined by the Board of Governors through its liaison member for public relations and the Committee on Legislation and Public Policy. The public relations program continued to stress positive activities aimed at the press, radio, television, general public, county medical societies, individual physicians and other organizations. The legislative program was devoted to several specific activities on the state and national levels in addition to maintaining the usual surveillance of all proposed legislation. The broad purpose of both programs was to provide the public, governmental bodies and the medical profession a constructive interpretation of the Association's actions, policies and services. Emphasis was placed also upon implementing and coordinating the various programs of the Association's standing and special committees serviced by the Bureau.

Personnel

Personnel of the Bureau consists of Messrs. W. Harold Parham, Supervisor, Eugene L. Nixon, Assistant Supervisor and Miss June Palmer, Secretary.

Field Activities

County Medical Societies—Attempts were made to achieve field contacts with each county medical society at least once during the year. On such calls all phases of Association programs were considered and conducted.

State—Numerous meetings of medical, allied and governmental groups were attended in behalf of the Association in many areas of the state. Many visits were made to newspapers, radio and television stations.

National—Meetings of medical and nonmedical groups were attended by Bureau personnel representing the Association. Among meetings attended were the AMA Annual Meeting, Clinical Meeting, Public Relations Institute, National Conference on Rural Health and conferences on legislation, care of the indigent and others.

Services to Officers, Committees, Specialty Groups, Other Departments and Members

Officers—Assistance to Association officers was provided in research material for speeches and other services relating to official duties. The President was accompanied by a staff representative in his attendance at many county medical society meetings.

Committees and Specialty Groups—Numerous Association committee and specialty meetings were attended and administrative and research functions performed. Among standing committees rendered such services were Child Health, Medical Education and Hospitals, Mental Health, Nursing, Poliomyelitis Medical Advisory, Representatives to Industrial Council, State Controlled Medical Institutions and Tuberculosis and Public Health.

Other Departments—Assistance to other departments was furnished whenever called upon in matters such as preparing special articles for The Journal and Briefs and providing many types of information. Administrative assistance was also provided to the Florida Medical Foundation in the numerous business details relating to its operation.

Member physicians—Requests received from individual physicians for information of many kinds were filled or referred to proper sources.

Services to County Medical Societies

Assistance was provided to county medical societies in planning, developing or expanding public relations and legislative programs as well as in solving specific problems or carrying out special projects. State speakers were obtained for society meetings upon request.

Services to the Public

Many written and oral requests for medical or health information were received from a variety of organizations and individuals throughout the state. Each request was answered individually or referred to proper sources.

Legislation

As in past years, special emphasis was placed upon assisting the Committee on Legislation and Public Policy in carrying out the Association's positive program regarding national and state legislation and liaison with governmental agencies concerned with health services.

Projects

Fair Exhibits—Successful public fair exhibits were planned and held in cooperation with local county medical societies in Tallahassee, Tampa and Orlando. Many thousands of persons attended these exhibits, each of which featured the recently-completed AMA exhibit "Digestion."

Liaison with Attorneys—Assistance was furnished in planning and staging, in cooperation with The Florida Bar, a series of three medico-legal institutes. The meetings, which were well attended by physicians and lawyers, were held in Miami, Jacksonville and Tampa.

Rural Health—Constructive activities in the field of rural health were continued with the Association's participation as a member of the Florida Committee on Rural Health. Dr. Francis T. Holland, of Tallahassee, was reelected to a second term as chairman of the committee. Other member groups of the committee are the Agricultural Extension Service of the two state universities, the Florida Farm Bureau Federation, the Florida State Board of Health and the Florida State Veterinary Medical Association. The latter group became a member of the committee early in 1958.

Science Fairs—Participation in the science fair program was initiated with the presentation of the Florida Medical Association Awards for aptitude for the medical sciences. The awards were presented in the 1957 State Science Fair in Gainesville by the then President Francis H. Langley. At this writing, plans are nearing completion for the second annual Association awards to be presented in the 1958 State Science Fair to be held in St. Petersburg in April.

Press Relations

Annual Meeting—Press room facilities were maintained during the Hollywood meeting for the convenience of the press in covering all newsworthy events. Complete kits containing information on the Association and advance news releases were prepared and provided to the press prior to the meeting. All possible assistance was rendered the press during the meeting. These activities resulted in wide coverage of the meeting in local newspapers as well as throughout the state by means of the wire services.

District Meetings—Advance news releases were prepared on each district meeting and distributed throughout the state by district. Assistance was rendered representatives of the press attending the meetings in developing additional stories.

Special Releases—News releases were prepared and distributed from time to time as required on various subjects such as polio immunization and fair exhibits.

Health Topics—Preparation and distribution of the Association's popular weekly "Health Topics" column service was continued. The mailing list includes nearly 100 weekly and semi-weekly newspapers.

Magazine Activities

In cooperation with the AMA Council on Rural Health, the Association continued to furnish medically-authenticated articles to the Florida Grower and Rancher Magazine for its monthly column "Farm Health," now in its second year of publication.

Radio-Television Activities

News Releases—All news releases furnished by the Association to the press in any single area or statewide have also been furnished to radio and television stations.

Annual Meeting—All possible assistance was provided to radio and television stations in covering the Hollywood meeting. Several news features were produced and carried by Miami stations. Assistance was furnished to Smith, Kline & French in producing and staging the closed-circuit "Videclinic" program.

Radio Programs—AMA transcribed 13-week radio health series were promoted, distributed and serviced throughout the state. The new AMA monthly radio series "Health Magazine of the Air," featuring newscaster H. V. Kaltenborn, was promoted and initiated on a special "network" of stations. Included with this service is a series of health and medical spot announcements designed for broadcast throughout each month.

Television Programs—A special kinescope of a 30-minute informational program on Asian influenza featuring Surgeon General Leroy E. Burney and AMA officers was obtained and placed on key stations early in the epidemic period. Films for television produced by the AMA were obtained and made available to stations on various occasions.

Motion Pictures

Numerous requests for AMA-produced motion pictures were received and processed. "The Case of the Doubting Doctors," the AMA membership indoctrination film, was furnished to nine county medical societies for showing. Through the cooperation of the AMA, a print of the automobile crash injury research film "On Impact," was made available to the film library of the Florida State Board of Health for showing in public schools, to civic organizations and other groups.

Literature Distribution

Stock of literature of many types were maintained and distributed to county medical societies, other organizations and the public at large. AMA publications such as "Your Family Health Record," "Personal Health Information Card," "What Everyone Should Know About Doctors," "AMA in Action," "Rx PR," "Health Today," and many others were distributed in large quantities.

FMA pamphlets such as "A Positive Public Relations Program," "Facilities, Methods, Activities of the FMA," "Code of Cooperation" for press, radio and television, "A Guide to Establish Close Cooperation Between Physicians and Lawyers in Florida," "The Florida Medical Foundation," "The Florida Committee on Rural Health," and others were furnished in large numbers.

A library of public relations reference literature was maintained. Packets of material of various subjects were prepared and furnished to county medical societies and individual physicians upon request.

ADMINISTRATION

In the past year, the Administration Department has completed the greatest workload in the history of the Association.

We now have a total membership of 3,316 on which a complete membership history is maintained, 1926 to date, or for the past thirty-three year period. The following table outlining membership growth in the past ten years will be of interest to the many members who have given whole-hearted support to the many Association activities through the years.

Year	Total Membership	Net Increase
1949	1,954	105
1950	2,032	78
1951	2,173	141
1952	2,285	112
1953	2,415	130
1954	2,537	122
1955	2,743	206
1956	2,909	166
1957	3,069	160
1958	3,316	247

Each new member of the Association is welcomed to membership by a personal letter from the President who sends him an attractive copy of the Oath of Hippocrates together with several pamphlets to acquaint him with the many services available to him through his Association.

The Administration Department is under the supervision of Mrs. Zoe Pack, Office Manager, and senior member of the office staff in years of service. Other members of this department in order of seniority are Mrs. Mae Mason, Miss Frances Pesce, Mrs. Janice Heying, Mrs. Rita Fitzgerald and Miss Jean Hightower. (Miss Hightower is no longer on the staff, having left the city, but will be replaced by a stenographer as soon as possible.)

Accounting Section

Bookkeeping records for the entire organization are maintained and monthly as well as annual budgets and statements are prepared for each department. The manual system of record-keeping which has been in use to date requires entirely too much time from our now over-crowded work schedule. The Board of Governors this year approved the purchase and installation of a Burroughs Machine Accounting System. Transfer from manual to machine will begin in June. With this new system, the posting and crediting of all dues, acknowledgments to members, the AMA and the county society as well as the banking of same can be handled in one simple machine operation now requiring the full time of one staff member and part-time of two others. Daily balances will also be maintained and statistical data will be available.

Medicare

The correspondence and reports on claims together with processing of committee minutes and directives consumes approximately 50% of the time of a top stenographer, leaving her very little time for processing of Board minutes, Placement and general correspondence.

Annual Meetings

Possibly, few members realize that before one annual meeting is over, plans are already underway for the next one. The details, records and correspondence in connection with the selection of the scientific program speakers, the technical and scientific exhibitors and other convention details are channeled through this department.

Purchasing

Monthly inventories are maintained on stationery and supplies for the entire organization by this department which issues purchase orders and processes payment. Careful consideration is given to methods of buying in order to effect as many savings as possible on all items purchased.

Placement

Every effort is made to assist young doctors seeking locations in the state as well as communities seeking doctors. Current listings are maintained and we endeavor to have the county society establish the fact that there is a definite need for another physician in the area.

Miscellaneous

Multilith masters are prepared for all "Briefs," the County Committee Booklet and the Yearbook for the Woman's Auxiliary. All copy reading is done, except for the latter. Once each year all membership as well as nonmember records are checked and Directory copy prepared for the printer.

After the two Medical Board examinations each year, two new record cards are prepared on each new licensee and lists prepared for publication in The Journal.

In this department we also prepare House of Delegates' proceedings and directives for publication in The Journal, revisions to the Constitution and By-Laws, Life Membership Certificates, Charters, all record forms, etc.

We feel proud that our department is fortunate in maintaining a staff of people who are not only congenial but as conscientious and devoted to duty as can be found anywhere.

Finances

The financial statements which follow are published for the information of the members. The books and records of the Association are open to members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich and Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Dr. Samuel M. Day, Secy.-Treas.
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Ernest R. Gibson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the association for the period March 21, 1957 to and including March 20, 1958, and submit herewith our report consisting of:

EXHIBIT "A"—Statement of Financial Condition
EXHIBIT "B"—Statement of Income for the Year
SCHEDULE "B-1"—Detail of Expenses shown in the aggregate in Exhibit "B"
EXHIBIT "C"—Schedule of Investments
EXHIBIT "E"—Schedule of Additions to Fixed Assets

We determined that all recorded receipts were deposited to the credit of the association and that the disbursements appeared to be for proper purposes.

The item of accounts receivable, offset by a reserve for deferred income, represents the aggregate of membership dues unpaid and the amount due the Journal by advertisers as at March 20, 1958. We made no attempt to verify these items.

The investments in United States Treasury Bonds were verified by actual count at the safety deposit vault.

In our opinion, the accompanying statements present fairly the assets and liabilities of the Florida Medical Association as at March 20, 1958, arising from cash transactions; the income collected and expenses disbursed by it during the year then ended on a basis consistent with that of the preceding year.

Yours very truly,
Goodrich & Varnedoe

CHG/d

Exhibit "A"
STATEMENT OF FINANCIAL CONDITION
March 20, 1958
ASSETS

CURRENT			
Checking Accounts:			
Atlantic National Bank	$53,876.31		
Florida National Bank	20,152.45	$ 74,028.76	
Savings Accounts:			
Atlantic National Bank	$ 4,020.00		
Florida National Bank	8,040.00		
Barnett National Bank	4,020.00	16,080.00	
Petty Cash Fund		100.00	
Deposit—Universal Travel Plan		425.00	$ 90,633.76
Accounts Receivable:			
Due from County Societies—Dues	$36,960.00		
Due from Journal Advertisers	8,227.84	$ 45,187.84	
Loss—Reserve for Deferred Income		45,187.84	-0-
Inventory—Stationery, Postage & Printed Matter			3,860.15
TOTAL CURRENT ASSETS			$ 94,493.91
INVESTMENTS—U. S. Treasury Bonds			16,155.37

FIXED	COST	Accumulated Depreciation	Book Value	
Land	$ 35,833.31	$ —	$ 35,833.31	
Building	122,708.52	5,764.22	116,944.30	
Furniture, Fixtures & Equipment	35,404.97	13,760.17	21,644.80	
	$193,946.80	$19,524.39		174,422.41
TOTAL ASSETS				$285,071.69

LIABILITIES AND NET WORTH

CURRENT			
Due American Medical Association			$ 25.00
NET WORTH			
Balance—March 21, 1957		$240,444.01	
Net Gain—Fiscal Year Ended March 20, 1958		44,602.68	
Balance—March 20, 1958			285,046.69
TOTAL LIABILITIES AND NET WORTH			$285,071.69

Exhibit "B"
INCOME STATEMENT
For The Period March 21, 1957 Through March 20, 1958

INCOME			
Dues—Current	$56,040.00		
Dues—Delinquent	85,680.00	$141,720.00	
Entrance Fees		3,380.00	
Advertising—Journal	$40,202.86		
Advertising—Directory	545.00	40,747.86	
Journal Subscriptions and Sales		674.50	
Directory Sales		3,182.00	
Technical Exhibits		22,245.00	
Reprints—Non-Member—Net		32.95	
Interest Earned		880.00	
Miscellaneous Income		1,560.73	
Medicare Program		1,398.02	
TOTAL INCOME			$215,821.06
EXPENSE			
Administrative)		($ 66,952.53	
Public Relations)		(30,916.11	
Publications) Exhibit "B-1"		(61,835.53	
Building Operations)		(11,514.21	
TOTAL EXPENSE			171,218.38
NET GAIN FOR PERIOD—To Exhibit "A"			$ 44,602.68

Schedule "B-1"
SCHEDULE OF EXPENSES
For The Period March 21, 1957 Through March 20, 1958

	Administrative	Public Relations	Publications	Building Operations	Total
Postage and Expense	$ 655.49	$ 837.18	$ 1,292.00	$ —	$ 2,784.67
Office Supplies	787.89	773.03	938.06		2,498.98
Telephone & Telegraph	1,066.29	1,352.26	719.52		3,138.07
Expense Account—Mng.	2,675.80	4,738.58			7,414.38
Student A.M.A.	600.00				600.00
Legal—Accounting Fees	825.00				825.00
Delegates to A.M.A. Convention	5,431.65				5,431.65
Maintenance—Office Equipment	386.72	197.56	171.63		755.91
Employees' Insurance	446.40				446.40
Building Insurance				1,265.56	1,265.56
Books, Pamphlets, Etc.	266.91	499.99	354.84		1,121.74
Salaries	29,473.43	16,214.88	8,351.07	3,066.26	57,105.64
Pension Plan Premium	7,732.03	1,256.00	2,481.63		11,469.66
Pension—Trustee Fee	100.00				100.00
President's Expense Fund	1,422.81				1,422.81
Secretary's Expense Fund	959.32				959.32
Printing & Engraving	704.96	959.09	1,750.90		3,414.95
Convention Expense—Net	6,398.43				6,398.43
Committee Expense	3,447.05				3,447.05
Dues & Fees	152.50	212.50			365.00
Miscellaneous Expense	281.18	15.00	185.40		481.58
President's Reception—Net	733.69				733.69
Depreciation	2,404.98			3,616.83	6,021.81
Special Projects		2,853.96			2,853.96
Legislation—Public Policy		1,006.08			1,006.08
Expense of Printing Journal, Etc.			42,616.81		42,616.81
Expense of Printing Directory, Etc.			2,973.67		2,973.67
Utilities				1,692.30	1,692.30
Janitor's Supplies				640.25	640.25
Cost of Heating—Fuel				180.47	180.47
Maintenance of Equipment & Plant				1,052.54	1,052.54
TOTALS—To Exhibit "B"	$66,952.53	$30,916.11	$61,835.53	$11,514.21	$171,218.38

Exhibit "C"
SCHEDULE OF INVESTMENTS
As of March 20, 1958

	Bond No.	Rate of Interest	Date of Purchase	Maturity Date	Face Value	COST
U. S. Treasury Bond	15431A	2½%	3/20/54	1962-67	$1,000.00	$ 978.44
" " "	99159K	2½%	3/20/54	1962-67	5,000.00)	
" " "	99160L	2½%	3/20/54	1962-67	5,000.00)	15,176.93
" " "	99158J	2½%	3/20/54	1962-67	5,000.00)	
TOTAL INVESTMENTS—To Exhibit "A"						$16,155.37

Exhibit "D"
DUES AND ENTRANCE FEES COLLECTED MARCH 21, 1957 THROUGH MARCH 20, 1958

Name of Society	Total Members	No. Paid Members	No. In Arrears	1958 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	64	60	4	2,160	240	20
Bay	30	22	8	800	280	10
Brevard	59	51	8	1,920	440	100
Broward	195	175	20	6,640	2,360	370
Collier	10	10	0	360		10
Columbia	13	12	1	320	80	30
Dade	828	396	432	14,200	31,600	740
DeSoto-Hardee-Highlands-Glades	28	16	12	440	160	20
Duval	346	174	172	5,200	5,800	220
Direct	2	2	0	80		
Escambia	114	101	13	3,720	760	90
Franklin-Gulf	6	6	0	200		
Hillsborough	233	188	45	6,840	2,240	220
Indian River	11	11	0	360		10
Jackson-Calhoun	15	15	0	560		
Lake	32	27	5	880	240	40
Lee-Charlotte-Hendry	40	37	3	1,320	200	40
Leon-Gadsden-Liberty-Wakulla-Jefferson	78	55	23	1,880	1,480	60
Madison	8	5	3	160	120	10
Manatee	32	32	0	1,200	160	60
Marion	34	6	28		1,080	20
Monroe	15	15	0	520	440	20
Nassau	9	9	0	240	40	
Orange	221	191	30	7,320	2,880	300
Palm Beach	165	142	23	5,320	1,240	130
Pasco-Hernando-Citrus	19	15	4	480	40	10
Pinellas	276	263	13	9,880	560	240
Polk	126	105	21	3,760	920	150
Putnam	13	11	2	320	40	20
St. Johns	22	21	1	760	40	60
St. Lucie-Okeechobee-Martin	30	19	11	720	440	90
Sarasota	83	81	2	3,040	160	140
Seminole	17	17	0	600		10
Suwannee	11	5	6	120	80	10
Taylor	6	6	0	160	40	10
Volusia	92	69	23	2,440	760	40
Walton-Okaloosa	33	23	10	680	1,080	70
Washington-Holmes	4	3	1	80	40	10
Totals	3,320	2,396	924	85,680	56,040	3,380

Dues Not Payable:			
Co. Soc. Secys.	37		
Life	110		
Excused	33		
Honorary	69		
Military Ser.	5	254	
Paying Dues		2,142	

56,040	Back Dues Collected
141,720	Total Dues Collected
3,380	Entrance Fees Collected
145,100	Dues and Entrance Fees

Exhibit "E"

SCHEDULE OF ADDITIONS TO FIXED ASSETS
For The Period March 21, 1957 Through March 20, 1958

	LAND	BUILDING	FURNITURE FIXTURES AND EQUIPMENT	TOTAL
BALANCE—March 21, 1957	$35,833.31	$122,708.52	$32,857.51	$191,399.34
Additions	-0-	-0-	2,547.46	2,547.46
BALANCE—March 20, 1958	$35,833.31	$122,708.52	$35,404.97	$193,946.80

REPORT OF THE EDITOR OF THE JOURNAL

Shaler Richardson, M.D.

Emphasis this fiscal year has been on making The Journal more interesting to readers and of greater service by providing a larger scientific section and reports of events within and without the Association so that members may be informed by the official voice of the Association.

Three years ago when publication of The Journal was made an activity of the Department of Publications, a program was begun to improve the appearance of the publication by changes in format and makeup. These changes, such as the use of more modern type styles, rearrangement of the makeup of various pages and the transfer of standing pages to other sections, have been taking place gradually.

This year, in order to entice the reader into a more thorough reading of the entire issue and also to improve appearance, color has been used on pages other than advertising. In each issue, there is color on the Contents page. At other times, it was used to draw attention to special features.

The use of color was a suggestion made at the State Medical Journal Conference held each two years in Chicago to which The Journal sends representatives.

Last year a gradual shift in editorial policy was begun with emphasis on making The Journal an active voice which speaks to members of the Association in an explanatory and advisory manner. This shift is being continued, however, the historical aspect of reporting events for the record has not been discontinued.

The Assistant and Associate Editors have contributed their opinions for each issue this year. Their editorials have been timely and thought provoking and, in some instances, have been reprinted by other publications for the benefit of their readers.

Members of the lay staff have endeavored by letters, telephone calls and their limited personal contacts to publish as much information as possible about seminars, postgraduate courses, county medical society events, the two medical schools and other significant events in which physicians would be interested. Members of the Association have cooperated with them most gratifyingly.

In a few months, the series of cover pictures "Doctors at Work" will be completed. There have been favorable comments about these covers, and for these comments, we are grateful.

For the fiscal year, The Journal had income of $55,907.69. Included is revenue from advertising, paid subscribers, non-member reprints and the allocation of subscriptions from dues paid by members. Expenses amounted to $40,621.81. Included as expenses are printing, paper, engraving, postage, drayage and other items necessary to production of The Journal. Salaries of lay personnel are not included since publishing The Journal is not their only activity.

A total of 56 scientific papers and 50 abstracts were published during the year. The 12 issues, a total of 42,670 copies, had 1,424 pages.

The entire staff is grateful to the many authors who submitted scientific papers and abstracts. Each paper was read by Dr. Chas. J. Collins or Dr. James N. Patterson, members of the Committee on Publication, before it was referred to me. I am personally grateful to each of them. Dr. Kenneth A. Morris, Chairman, and Dr. Walter C. Jones, were responsible for the Abstract Department, and I am indebted to them.

Sincere appreciation is expressed to the Assistant Editors, Drs. Webster Merritt and Franz H. Stewart, and to the Associate Editors, Drs. Louis M. Orr, Joseph J. Lowenthal, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar, Walter C. Payne Sr., George T. Harrell Jr., and Homer F. Marsh.

Members of the lay staff have my special thanks: Mr. Ernest R. Gibson, Managing Editor, who directs the work of publication, Mr. Tom Jarvis, Assistant Managing Editor, and Mrs. Louise Rader, Technician, who devote most of their time to The Journal, and Mrs. Edith B. Hill, who is available at all times as Editorial Consultant.

This completes my 30th year as Editor. It has been an honor and a privilege to have had a part in the growth of The Journal in this period.

PRESIDENT'S PAGE

From the Recent Convention . . . .

several facts are readily apparent. Foremost is the emergence of the Florida Medical Association from the boisterous rowdyism of its adolescence into the adulthood of a mature, reasonable, deliberative body capable of conducting its affairs with dignity and dispatch.

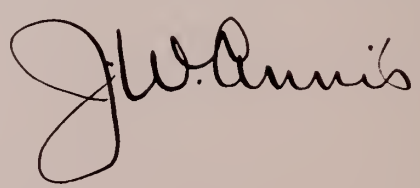
The controversial Blue Shield issues, as vital and as personal as they are to our organization and to its individual members, were discussed and adjudicated in a manner designed to set an example for all such future meetings. The long sessions of restrained and courteous debate provided opportunity for the unhurried and unlimited presentations of many points of view. Fine oratory and simple expression of honest conviction were heard, and the sincere results of long hours of thought and controversy emerged. Statesmanship, indulgence and cooperation were indeed the order of the day.

I doubt that anyone who attended these sessions left Bal Harbour with exactly the same point of view that he carried to the meeting. Each was impressed and affected by what he heard. The patient, sympathetic and understanding attention with which each speaker was received reflected the deep-seated interest and integrity of the reference committee which so distinguished itself. Truly, this has been a milestone in our history—and congratulations are in order to the committee and to all discussants who took part in formulating the final opinion of the House. Each individually deserves our abiding admiration and respect.

Again it was evident that there are still too few devoted and conscientious servants of Organized Medicine—although today we can count more than one hundred, instead of the dozen or so of years gone by. These men, by their tireless efforts, keep the cumbersome vehicle that is Modern Medicine rolling along the road of progress, abreast or ahead of all other disciplines. It behooves those among us who are just riding to get down and help supply the impetus that moves us all along. More are doing just this, as new issues confront us—but there is still lots of room. Let's all get into the act.

One discordant note in a wonderful convention was the lack of attention and appreciation shown our good friends the Medical Exhibitors. These gentlemen who contribute so substantially to the financial success of our meeting found themselves unable to justify the expense of their exhibits on the basis of the very poor attendance at their booths. Unless this can be corrected, we stand to lose these good friends at our meetings. These men have long been our allies and our effective ambassadors of good will, and we are guilty of bad manners in neglecting them and in taking them for granted. Next year it is our responsibility as hosts to rectify this breach of manners in an effective and impressive fashion, and to show these friends our interest in their continuing presence at our Conventions.

All in all, it was a fine meeting, in wonderful surroundings—and it was good to see all 1,986 of you there.



THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Highlights of 1958 Annual Meeting

At the Eighty-Fourth Annual Meeting of the Florida Medical Association, held at Bal Harbour the second week in May, Dr. Jere W. Annis of Lakeland succeeded Dr. William C. Roberts of Panama City in the office of President. Dr. Ralph W. Jack of Miami was chosen President-Elect, and Dr. S. Carnes Harvard of Brooksville succeeded Dr. Jack as First Vice President. Dr. Walter E. Murphree of Gainesville was re-elected Second Vice President, and Dr. Joseph W. Douglas of Pensacola was elected Third Vice President, succeeding Dr. James T. Cook Jr. of Marianna. Dr. Samuel M. Day, Secretary-Treasurer, and Dr. Shaler Richardson, Editor of The Journal, both of Jacksonville, were re-elected.

The Americana Hotel in Bal Harbour was the scene of this year's convention, and the Association will return there for its next annual meeting, scheduled one week earlier than this year's meeting. The dates set by the Board of Governors are May 2 to 6, 1959. If adequate facilities are available, Jacksonville will be given serious consideration as the site of the 1960 meeting. While the 1958 physician attendance and total registration did not reach the 1957 record-breaking mark, there were 937 members of the Association registered and 158 visiting physicians in attendance. The total registration was 1,986. The Annual Dinner was resumed this year, and the advisability of continuing this former social function was by official action left to the Board of Governors to determine.

Of paramount interest was the action of the House of Delegates on Blue Shield problems. The House concurred in the recommendation of the Advisory Committee to Blue Shield that Blue Shield be continued and given every support necessary to keep it successful. It requested Blue Shield to issue a new service benefit contract with a $5,000 level for a family and $3,600 for a single person. It also requested Blue Shield to explore further the possibility of a prolonged illness contract and to study the possibilities of a special category old age contract with low fee schedule and low service benefits, a deductible Blue Cross contract or contracts, and an outpatient diagnostic x-ray rider and a general diagnostic rider. Approval was given to the recommendation that the present Blue Shield contract be maintained and that study be made to make it equitable along



Dr. Jere W. Annis, Lakeland
President



Dr. Ralph W. Jack, Miami
President-Elect

the lines of the new contract proposed. It was recommended that no fee schedule or service benefit level be considered static and that reappraisal every year or two years be mandatory. As soon as the contract problems have been worked out, every means including a doctor's reference handbook will be used to give the members of the Association intimate knowledge of their own Plan. The Committee of Seventeen, as the Advisory Committee to Blue Shield is commonly called, received well earned commendation for the extraordinary amount of service rendered in carrying out its difficult task.

In keeping with a nationwide concerted movement to launch an adequate program aimed at improving the health care of the aged, the House established a Committee on Aging. This program and the duties and membership of this new Committee are discussed in a commentary entitled "New Program for the Aged," published in this issue of The Journal.

The House recommended that the Florida State Board of Medical Examiners proceed with the revision of The Medical Practice Act, in consultation with the Association's Committee on Legislation and Public Policy. The report of this board summarized numerous proposed changes for modernizing the Act.

The Committee on Representatives to Industrial Council reported on its review of the Workman's Compensation Fee Schedule. The House accepted its recommendations for establishing a standard nomenclature and relative value units as a basis for negotiations with the Florida Industrial Commission on the Workman's Compensation Average Fee Schedule. It also approved the suggestion that this Committee consider such other problems in Workman's Compensation cases as free choice of physician, vocational training coordinated with medical care in the total treatment of the patient, and the advisability and feasibility of establishing a rating board to determine disability on the basis of the medical record.

Looking ahead to the June meeting of the American Medical Association in San Francisco, the House gave its wholehearted endorsement to the nomination of one of its most distinguished members as President-Elect of the American Medical Association. By resolution introduced by Dr. Homer L. Pearson Jr., it instructed him to nominate Dr. Louis M. Orr of Orlando for this high office in the name of the President, the House of Delegates and the members of the Association. Long a representative of the Association in the House of Delegates of the American Medical Association, Dr. Orr has rendered outstanding service and now serves as Vice Speaker of that body.

The annual District Meetings were officially discontinued by action of the House on recommendation of the Council and the Board of Governors. This action seemed wise in view of the declining attendance and apparent lack of interest in these meetings. The Board of Governors will give due consideration to the type of activity which should replace them.

A resolution on revision of The Journal of the Florida Medical Association was passed by the House which requires a change in the Constitution that will become effective as soon as it is duly ratified by three fourths of the component county societies. This action places The Journal under the direct supervision and guidance of the Board of Governors, and the Board will select annually from the membership at large an Editor, who will determine the general policies and procedures of The Journal, subject to approval by the Board.



Left to right: Dr. S. Carnes Harvard, Brooksville, First Vice President; Dr. Walter E. Murphree, Gainesville, Second Vice President, and Dr. Joseph W. Douglas, Pensacola, Third Vice President.

The House strongly disapproved the Forand Bill (HR 9467) or any such type of legislation that would amend Title II of the Social Security Act by introducing a hospital and medical benefit, thereby establishing a national system of compulsory health insurance. This bill is the most controversial medical bill to be offered at the present congressional session.

Endorsement was given to two resolutions recommending initiation of the necessary measures to make the possession or sale of BB guns or air rifles illegal in the State of Florida. This legislative matter was referred to the Committee on Legislation and Public Policy for study and action.

Favorable action was taken on the recommendation of the Committee on Legislation and Public Policy that this Committee shall present state legislation which is to be sponsored or opposed by the Association to the First Meeting of the House of Delegates at its annual meeting the year preceding the convening of the regular session of the legislature. Between meetings of the House the Association's policy regarding legislation is to be left to the discretion of the Committee in consultation with the Board of Governors.

Approved and also referred to the Committee on Legislation and Public Policy was a resolution on compulsory immunization of school children.



Samuel M. Day, M.D., Jacksonville
Secretary-Treasurer



Shaler Richardson, M.D., Jacksonville
Editor of The Journal

By this action the Association sponsors legislation requiring that all children in the state be required to present a certificate of inoculation against diphtheria, pertussis, tetanus, smallpox and poliomyelitis as a condition for admission to a public school, the only exception being bona fide objectors on the basis of religious or medical grounds.

The convention was constructive and stimulating with the entire day on Tuesday devoted to an excellent scientific program. The Americana, the Hotel of the Americas, provided a unique and luxurious setting for the occasion and will no doubt entice the members back for the 1959 session in record numbers.

New Program for the Aged

A comprehensive program for better health care for the nation's 14 to 15 million aged persons has recently been undertaken by four important national organizations. The sponsoring group, known as the Joint Council to Improve the Health Care of the Aged, is composed of the American Medical Association, the American Dental Association, the American Hospital Association and the American Nursing Home Association. Its attack on the difficult problems of health care for the aged is designed to: (1) increase opportunities for older people to obtain voluntary health insurance coverage, (2) expand health care facilities tailored to the needs of the aged regardless of economic status, and (3) develop more community health services for the aged.

"Member organizations of the Joint Council," said Dr. Edwin L. Crosby, the director of the American Hospital Association and the interim secretary of the Joint Council, "have already undertaken studies and work projects aimed at improving the health care of the aged." Among the many activities which these groups have undertaken or in which they have cooperated he listed the following:

1. The American Hospital Association, in cooperation with the Public Health Service, is conducting a conference on the care of patients with long term illness.

2. An American Medical Association committee is working with the American Nursing Home Association in preparing upgraded standards for nursing homes which will result in improved nursing home care for the aged.

3. A national conference on homemaker services is being arranged under the joint auspices of the Department of Health, Education, and Welfare and 26 national voluntary organizations including the American Medical Association. This project is aimed at reducing the financial expense of disabling illness among the elderly by performing the necessary household tasks to enable them to remain at home among their family and friends, with qualified nursing and medical attendance in the home.

4. Six regional conferences have been held under the auspices of the American Medical Association to help doctors cope with problems of the aged, and a national conference will be held in September.

The Joint Council will appraise the success of these programs and seek their application through united effort. In discussing this program in his address at the recent meeting of the Florida Medical Association, Dr. David B. Allman, President of the American Medical Association, said, "A vast movement is currently under way to attack the problem with intelligence, enlightened understanding and personal concern . . . the Joint Council proposes to apply all its knowledge and skills to seek improved health care for the aged: we offer the aged hope for a better life, not a crutch; we offer them a return to the mainstream of community life and usefulness, not a one way ticket to limbo."

In line with this nationwide movement, the House of Delegates established a Committee on Aging, consisting of one member from each of the four medical districts and one member at large, to be appointed by the President. The Committee will study the problems of aging persons with regard to adequate and appropriate medical services and facilities, make recommendations for effecting advisable measures, and work in liaison with acceptable voluntary and governmental organizations or agencies interested in this endeavor.

Dr. Dame Honored on Retirement

On April 30, 1958, Dr. George A. Dame of Jacksonville retired from his duties as Director of the Bureau of Local Health Service of the Florida State Board of Health, terminating an association extending back to June 15, 1917. At an informal gathering in the Conference Room of the State Board of Health on that date, tribute was paid

to this distinguished Georgian for his outstanding contributions in the health field in Florida, and he was presented with suitable tokens of appreciation.

Dr. Wilson T. Sowder, State Health Officer, said of Dr. Dame and his work, "We believe that it is largely due to his efforts in recruiting personnel and dealing with local officials that we have one of the best county health departments in the country." He lauded Dr. Dame's remarkable knowledge of the state and of the people of the state, his knowledge of human nature and his keen ability to judge people he has contacted up and down the 900 mile area stretching from northern Florida to the southern tip of the state.

On behalf of the Florida Medical Association, Dr. Sowder presented Dr. Dame with a certificate of life membership in the Association. "We are all sorry to see him leave," said Dr. Sowder, "but we are glad that he is hale and hearty and can enjoy some of his own plans after giving so much of himself for improved health service throughout the state." Dr. Dame is spending the summer in the British Isles.

New President Addresses Other Professional Groups

Dr. Jere W. Annis, newly installed President of the Florida Medical Association, found the duties of the presidency crowding in on him immediately upon acceding to that high office. Within 24 hours he was addressing the Florida Bar Association, which was holding its annual convention in Miami Beach. Commenting on the success of the liaison committee established by the two professions some years ago and on the jointly sponsored medicolegal institutes recently favorably received throughout the state, Dr. Annis said:

"Much remains to be done, but such an auspicious beginning leaves no doubt as to future accomplishments. It is my own hope that a state committee on medical testimony may one day be established to aid the court in the many difficult situations of conflicting testimony and opinion, and to control professionally, to a degree at least, the zeal, the bias, and the occasional conscious deviation from accepted fact found in expert testimony. Such a committee might, it seems to me, do much to aid and dispatch the administration of justice, as well as to preserve the sense of integrity which traditionally reposes in your profession and mine. For, as I have said, our goals are the same, and whether we meet in the courtroom or the sickroom, whether we stand at the bench or the bedside, we are both concerned with the welfare of an individual, the preservation of the health—material or physical—of one man. We are both dedicated to a client or a patient, and when we meet, it should be as consultants—not as contestants.

"Together our two organizations represent over 10,000 of the most intelligent and influential people in Florida. We can do much for the individual and for the state. Through harmonious cooperation our accomplishments can be exceeded only by our responsibilities—and our honest efforts only by the pleasure derived from them."

Two days later, on May 17, President Annis appeared at the Health Center of the University of Florida in Gainesville to speak on "Public Relations" at the First Annual Florida Conference for Veterinarians. "The keystone of your arch of public relations," he advised this new state organization, "must be in your small county society—the smallest unit of your state group—where the individual is more prominent than anywhere else in the organization. Fundamentally, public relations is a local problem. It comes back to the local doctor and the local association. The grass roots are all important. Organization must be from the ground up, not from the top down; and the basic unit remains the important and vital one. Your state group should stand firm and united, presenting a strong and solid front in moving toward its objectives. The ultimate goal will be obtained only when every practitioner of your profession makes it his particular concern to participate in promoting amicable understanding between himself and the public, both in his own community and throughout the state and nation."

"How important is this problem of public relations to you as individuals?" Dr. Annis continued. "It is as important as a transfusion in a case of exsanguination. It is so important that without it you cannot fulfil your obligations to your profession or to yourself. Without it you cannot effectively preserve the dignity that should be a part of every physician—you cannot preserve your proper place in the community, or your intellectual, moral and economic integrity."

Change in Veterans Administration Form

The following information regarding a change in Veterans Administration forms for reporting medical treatment is published at the request of Dr. Frederick H. Bowen, of Jacksonville, who is chairman of the Board of Governor's Subcommittee on Veterans Care.

"Procedures have been established by the Veterans Administration utilizing machine recording for medical services. This necessitates a change in forms used for authorizing fee-basis care.

"Your authority to treat the veteran identified on form 10-2989a, Authorization for Medical Services, is for the disability shown in Item 5. The services authorized are listed in Items 7, 8 and 9. If additional services are necessary for his service connected condition during the authorized period, please list them on your statement and give a full explanation on your professional report, VA Form 10-2690a. Your medical findings and report of treatment is to be recorded in the top section (and on the reverse side if required). The lower section of the front is to request continued treatment. This form should be mailed to this office promptly after the last treatment in the month—*(Before the 15th of the following month).*

"The request for continued treatment should cover the *second month following* the period covered by the report given at the top of the 10-2690a. For example, your report of treatment rendered during *June* would be followed in the Request for Continued Treatment Section with the estimated visits or services required during *August. We have automatically carried your case for one month to allow this system to become effective."*

First Group Contribution For Medical Student Aid

The first group contribution of $1,000 for medical student aid at the University of Florida College of Medicine was made recently by the Daughters of the American Revolution. Mrs. Edward Everett Adams of Winter Haven, who is state regent of the Florida State Society of D.A.R., presented the check to Dr. George T. Harrell Jr., Dean of the College of Medicine. The organization numbers 5,000 persons in chapters throughout the state.

Attending the brief ceremony were: Mrs. R. H. Ferris of Ocala, state chaplain; Mrs. Albert Vidal of Gainesville, chairman of the state committee on student loans and scholarships; Mrs. George E. Evans, regent for the Gainesville chapter; and Mrs. Jackson E. Stewart of Orlando, state vice regent.

"Contributions have been made by individual physicians for medical student aid," Dr. Harrell said, "but this is the first group effort made for this much needed program." At the present time medical education is expensive, he explained, and it is particularly difficult for the needy student because he cannot work to supplement his income for these years.

Mrs. Adams said the purposes of the society are educational, historical and patriotic and the gift will provide for a revolving student loan fund which will foster medical education directly at the student level. Mrs. Vidal headed the committee which surveyed the needs and which recommended the loan fund to be designated as the Florida State Society Daughters of the American Revolution.

OTHERS ARE SAYING

Medical Moonlighting?

The *Westchester Medical Bulletin*[1] comments editorially on "The Physician's Wages in a Collectivistic Society" in a recent issue:

> Not so long ago the American public and our medical profession barely escaped the imposition of socialized medicine in the form of compulsory health insurance. This was due in part to last minute vigorous group action directed by our American Medical Association.
>
> Our British brothers in the profession now know by bitter experience how poor are the fruits of their labors in a Socialistic society. Recently a threat of mass resignation from the Health Service was necessary to force an improvement in their economic status.
>
> Therefore, it does not come as a surprise to learn how poorly the physician is paid for his services in the Soviet Union. William J. Jordan of the *New York Times* reported recently on interviews with 11 Russian citizens selected to represent a variety of occupations, incomes, and localities. The physician received the very lowest base pay of all individuals interviewed, including a bus driver, farmer, and steelworker.
>
> The economic and social status of our profession in other countries should be carefully watched and analyzed so that we can effectively resist the forces calculated to enslave us.

To many people in these times, maintaining what we might call a "freedom watch" seems to be either a matter of indifference or at best a part-time job. In industry when a man has two jobs, his regular one and another which he carries on for a few hours at night, he is known as a "moonlighter" for obvious reasons. Many of us

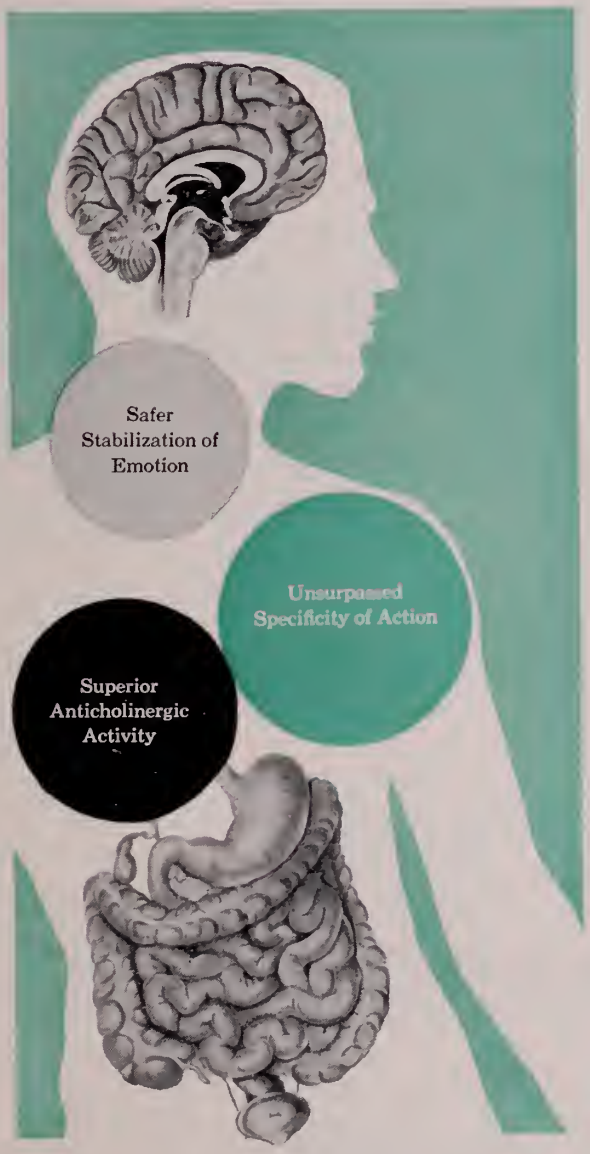
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Dosage: One tablet three times a day.

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doctors might be called "medical moonlighters" with respect to the way we work at the maintenance of our freedoms, considering this function if at all as an extra job to be taken on after our regular day's work is finished. Maybe it can be done that way but we have doubts; maybe our day's work is never finished, but that is the greater reason for us to work at both jobs at the same time.

History will show that since the Magna Charta was wrested from King John, there has been a succession of attempts to nullify the gains secured by this document. Again and again the people's hard won rights were lost to scheming and ambitious seekers after power; the struggle to retain these rights is a twenty-four hour job on the part of everyone. Medicine has been and continues to be a prominent point of attack by those who would convert this Republic to a Socialist state. The preservation of the free enterprise system in the light of history is a full-time job and particularly so for physicians. Medical moonlighting can spell disaster.

[1]Westchester M. Bull.: 26:18 (Jan.) 1958

New York State Journal of Medicine
April 15, 1958

STATE NEWS ITEMS

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, served as a consultant on the Guidance and Mental Health Section of the Audio-Visual Conference held June 17-18 at Florida Southern College, Lakeland.

The first annual meeting of the Medical Progress Assembly will be held in the Tutwiler Hotel at Birmingham, Ala., September 7-9, sponsored by the Birmingham Academy of Medicine. Sixteen of the country's outstanding medical authorities will appear on the scientific program.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, has been elected Vice Chairman of District IV of the American College of Obstetricians and Gynecologists. The selection of Dr. Jack took place during the Sixth Annual Clinical Meeting held April 21-23 at Los Angeles. The next meeting is scheduled for April 6-8, 1959 in Atlantic City.

Dr. John C. Ajac of Coral Gables will be in London, England, July 6-12, attending the International Cancer Congress. He will also visit clinics and hospitals in Scotland before returning home.

Dr. Kip G. Kelso of Vero Beach has been elected president of the Florida Trudeau Society succeeding Dr. Howard M. DuBose of Lakeland. Dr. Charles F. Tate Jr. of Miami was chosen vice president and Dr. George H. McCain of Tallahassee, secretary.

Dr. Simon D. Doff of Jacksonville has been installed as president of the Florida Heart Association, and Dr. Sidney Davidson of Lake Worth has been elected president-elect. Other officers include Dr. Daniel R. Usdin of Jacksonville, vice president, and Dr. Claude G. Hooten Jr. of Clearwater, executive vice president.

Occupational Medicine, a full-time course aimed at meeting the need for specialized training in industrial medicine, will be offered by the New York University Post-Graduate Medical School



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1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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from September 15 through November 7. Information may be obtained from the Dean of the School, 550 First Avenue, New York 16, N. Y.

Drs. E. Sterling Nichol of Miami and Alexander Libow of Miami Beach were among Florida physicians taking part in the program of the 24th Annual Meeting of the American College of Chest Physicians held June 18-22 at San Francisco. Dr. Nichol discussed "Resuscitation of Heart—Treatment of Cardiac Arrest" during the series of Fireside Conferences, and Dr. Libow was a member of the panel which had as its topic "The Management of Pulmonary Disease in Geriatric Patients."

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The 60 members of the third graduating class of the University of Miami School of Medicine will serve internships in 33 different hospitals in 15 states, Hawaii and the District of Columbia, according to announcement by Dr. Homer F. Marsh, Dean. Dr. Marsh also announced that 19 students had been awarded fellowships for summer study in the medical sciences.

Dr. Robert J. Needles of St. Petersburg was among the group of Florida physicians who attended the recent meeting of the American College of Physicians held at Atlantic City.

Dr. Cyrus E. Warden of Melbourne was final speaker in the series of career clinics sponsored by the Melbourne-Eau Gallie Business and Professional Women's Club. Dr. Warden discussed "Medicine as a Career for Women."

Dr. George W. Karelas of Newberry, a member of the Committee on Rural Health of the American Academy of General Practice, was principal speaker at a recent meeting of the Woman's Club of High Springs. His subject was "Geriatrics Today."

Dr. Grover W. Austin of St. Petersburg has been elected treasurer of the Southeastern Society of Plastic and Reconstructive Surgeons, an organization formed recently at a meeting held in New Orleans.

An initial $5,000 gift setting up the William G. and Mary Selby Foundation Medical Loan Fund at the University of Florida College of Medicine, Gainesville, has been announced by Dr. George T. Harrell Jr., Dean. The Fund will allow students to borrow up to $1,000 a year and repay when they are self-supporting after graduation.

Dr. G. Dekle Taylor of Jacksonville attended the recent meeting of the Triological Society held at San Francisco.

Mr. Alvin James Woodring has been appointed assistant director of the University of Florida's Teaching Hospital at Gainesville. He was formerly administrator of the Fairfield County Hospital in Winnsboro, S. C.



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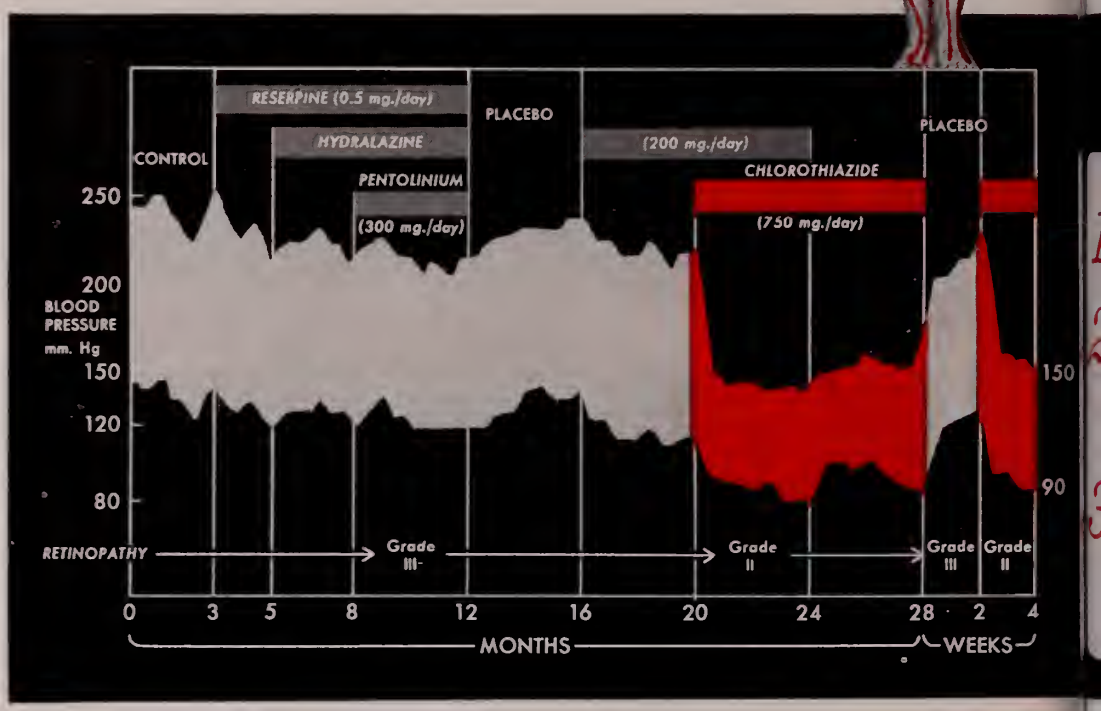
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September 1957.

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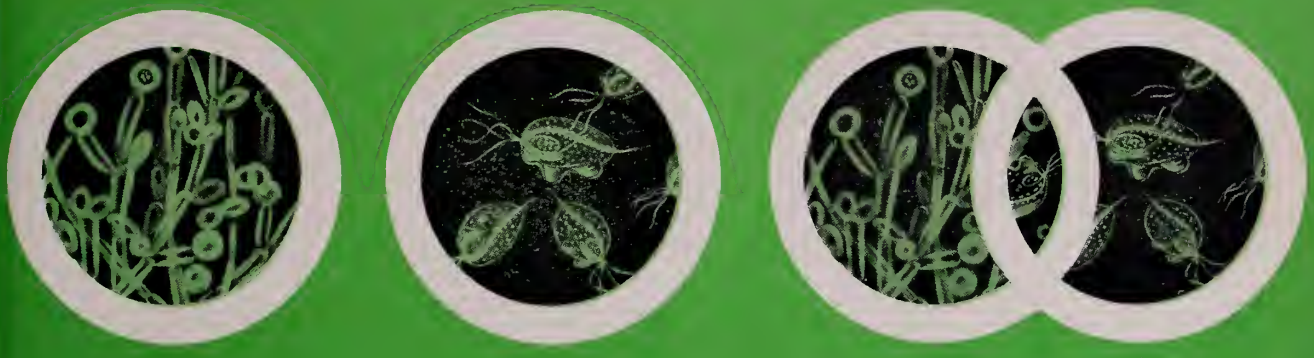
25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
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1450 Broadway, New York 18, N. Y.

for vaginal moniliasis, trichomoniasis or both



a new specific **moniliacide** MICOFUR™ (brand of nifuroxime) is combined with the established specific **trichomonacide** FUROXONE® (brand of furazolidone) in

TRICOFURON® IMPROVED

VAGINAL SUPPOSITORIES AND POWDER

85% CLINICAL CURES* In 219 patients with either trichomonal vaginitis, monilial vaginitis, or both, clinical cures were secured in 187.

71% CULTURAL CURES* 157 patients showed negative culture tests at 3 months' follow-up examinations.

Simple two-step treatment swiftly brings relief and control of vaginal moniliasis and trichomoniasis.

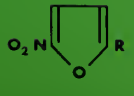
STEP 1 *Office* administration of TRICOFURON VAGINAL POWDER IMPROVED Applied by the physician at least once a week, except during menstruation.

(Micofur 0.5% [*anti* 5-nitro-2-furaldoxime], the new nitrofuran fungicide, and Furoxone 0.1% in an acidic, water-soluble powder base). Plastic insufflator of 15 Gm., with 3 sanitary disposable tips. Also glass bottle of 30 Gm.

STEP 2 Continued *home* use to maintain moniliacidal-trichomonacidal action: TRICOFURON VAGINAL SUPPOSITORIES IMPROVED Employed by the patient each morning and night the first week and each night thereafter—through one cycle, especially during the important menstrual days.

(Micofur 0.375% and Furoxone 0.25% in a water-soluble base) **NEW:** Box of 24 bullet-shaped suppositories, each hermetically sealed in green foil; with applicator. Box of 12 wedge-shaped suppositories without applicator.

*Combined results of 12 clinical investigators. Data available on request.



NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides

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COMPONENT SOCIETY NOTES

Brevard

A feature of the March meeting of the Brevard County Medical Society was a film on hypothyroidism presented by Dr. Louis C. Jensen Jr., of Rockledge. The meeting was held at Cocoa Beach.

The Society's April meeting was held at the home of Dr. Roberts in Indiatlantic. Following the business meeting, Dr. Jensen showed a series of slides on cardiac disease.

Dade

Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine, was principal speaker at the May meeting of the Dade County Medical Association. Dr. Marsh gave a "Report on Progress of the Medical School."

Duval

Dr. Ivan Bennett, of Johns Hopkins University School of Medicine, Baltimore, was principal speaker at the June meeting of the Duval County Medical Society. The title of his address was "Staphylococcus Problems."

Hillsborough

Members of the Hillsborough County Medical Association met jointly with members of the Auxiliary at the May meeting. Dr. Herbert S. Alden, Professor of Dermatology at the Emory University School of Medicine, was principal speaker. His subject was "Medicine on Trial."

Lake

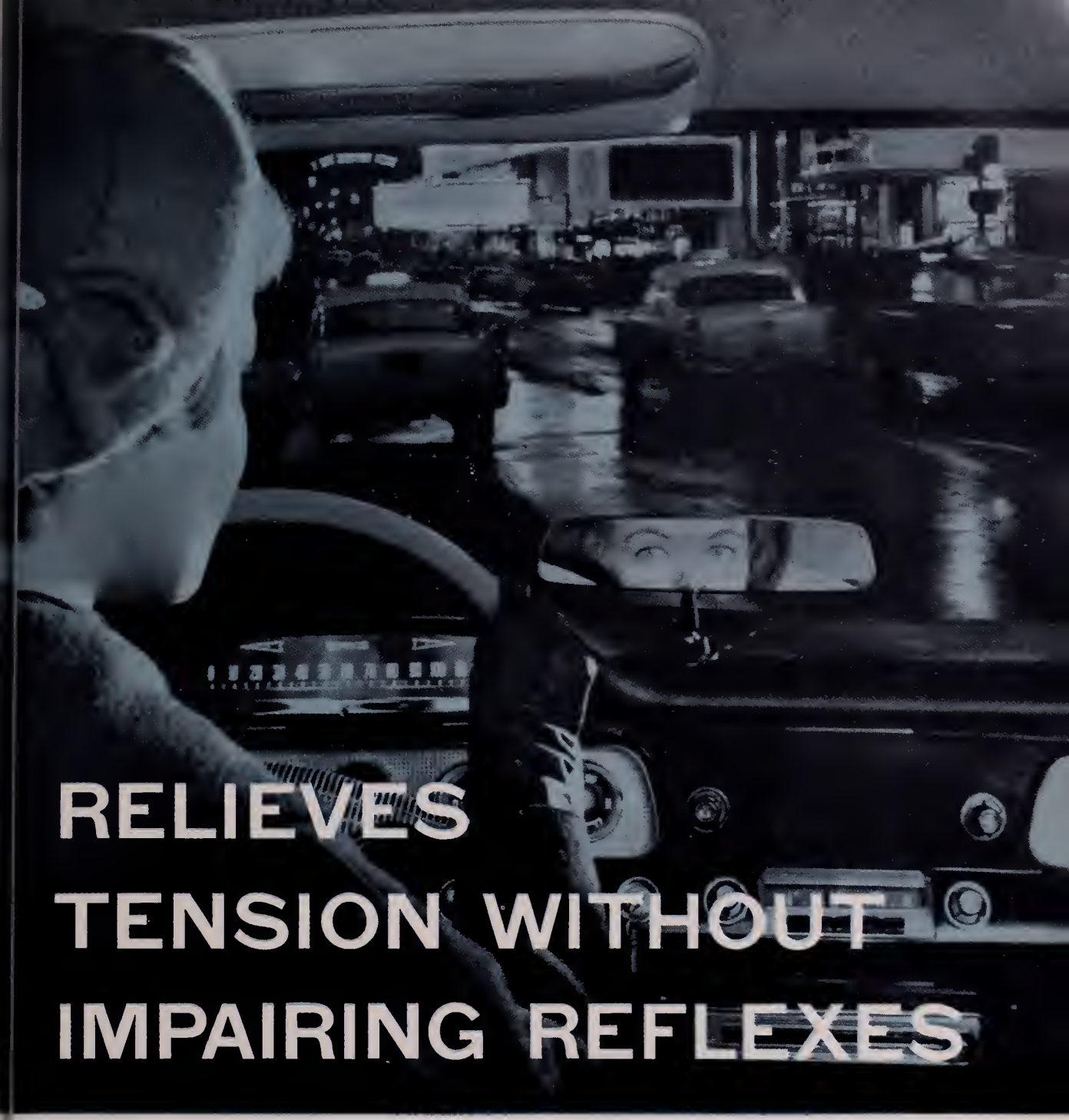
For the tenth consecutive year, members of the Lake County Medical Society have performed the physical examinations and given all the inoculations to the members of the Florida National Guard companies located in Eustis and Leesburg.

Drs. Thomas E. Langley and Raymond A. Debo, of Eustis, and Dr. Leroy H. Oetjen, of Leesburg represented the Society in performing this public relations service.

Marion

The Marion County Medical Society held its May meeting at the home of Dr. and Mrs. John D. Lindner Sr., where a buffet supper was served by members of the Woman's Auxiliary. Dr. Edward R. Woodward, Professor of Surgery at the University of Florida College of Medicine, Gaines-





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Usual Dosage:
One or two
400 mg. tablets t.i.d.

Supplied:
400 mg.
scored tablets,
200 mg.
sugar-coated
tablets,
bottles of 50.

*Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

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ville, was principal speaker. Dr. Woodward discussed the present and future status of the college.

Volusia

The annual party of the Volusia County Medical Society and its Auxiliary was held at the Ellinor Village Country Club the evening of May 31. A social hour, dinner and dancing was the program for the event.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

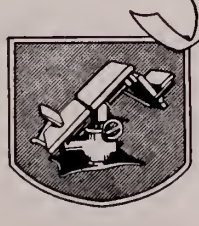
Baird, Duke B., No. Miami
Banks, Keith D., Fort Lauderdale
Bauer, David P., Jacksonville
Bender, Rosarie, Fort Lauderdale
Berg, George S., Miami
Berger, Robert L., Hollywood
Blake, Thomas F., Miami
Blank, Harvey, Miami
Blum, Edward B., So. Miami
Boggess, Shelby F. II, No. Miami
Bolton, John W., Miami
Borken, Norman, Miami Beach
Bramson, Morton B., Miami Beach
Burdette, Marvin G., Winter Haven
Cava, Edmund, Miami Beach
Cogan, Michael A., Miami Beach
Converse, J. Gerard, Miami
Dembrow, Victor D., Miami
Dunn, Seymour, Hollywood
Freedman, Robert H., Daytona Beach
Friedman, Marcia G., Miami
Furlong, Paul J., Miami Beach
Gilbert, Robert G., Coral Gables
Glover, Nathan, Miami
Hanson, Eugene W., St. Petersburg
Hardin, Marvin S., Coral Gables
Harrison, I. Barnett, Tallahassee
Hills, A. Gorman, Miami
Hoffman, Erwin P., Miami Beach
Horwich, Harry, Coral Gables
Jacobson, George, Miami
Joest, Charles O., Jacksonville
Justiz, Charles T., Miami
Kane, Thomas M., Daytona Beach
Kaplan, Allan A., Miami Beach

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Kilpatrick, John T., Miami
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MacKenzie, Malcolm, Dunedin
Mahon, Chester W. Jr., Zephyrhills
Maraist, Francis B., W. Palm Beach
March, Alfred L., No. Miami Beach
Monnin, Charles A. Jr., Miami
Morgen, Maximilian, Miami
Moskowitz, Harry, Miami
Nixon, Joseph J. III, Augusta, Ga.
Notarius, Morton S., Miami
Padilla, Jose B., Miami
Palmisano, Peter J., St. Petersburg
Paty, Philip B., Dunedin
Paxton, George B. Jr., Miami
Phillips, Curtis M. Jr., Jacksonville
Reynolds, Georgia, Fort Lauderdale
Schwartz, Robert C., Miami
Seda-Morales, Ruben, Bradenton
Shepperd, Lewis A., Miami Beach
Sher, David D., No. Miami Beach
Smith, Stuart C., Tallahassee
Stanley, Thomas Z., Pensacola
Steinborg, Robert J., Fort Lauderdale
Thatcher, Arthur K., Rockledge
Thatcher, Jackson L., W. Palm Beach
Thompson, Hugh S. Jr., Chipley
Wagner, Rudolph T., Miami Beach
Wessel, George H. V., Hialeah
Womble, William L., Dunedin

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Seymour W. Rubin, of Miami Beach, announce the birth of a daughter, Wendy Klein, on December 27, 1957.

Dr. and Mrs. Curtis M. Phillips, of Jacksonville, announce the birth of a son, Steven Cary, on April 16, 1958.

Dr. and Mrs. Arthur I. Parvey, of Jacksonville, announce the birth of a daughter, Mae Stephanie, on April 3, 1958.

Marriage

Dr. Lorenzo L. Parks, of Jacksonville, and Miss Lucy Geodert, of Winter Haven, were married June 3, 1958, in Jacksonville.

Deaths — Members

Moses, Harry, Palm Beach	March 20, 1958
Roth, Julius A., Delray Beach	March 19, 1958

Deaths — Other Doctors

Lindgren, Elis I., Lake Worth	January 21, 1958
Ponder, James M. (Col.), St. Petersburg	March 4, 1958
Sharrer, Harry E., Sarasota	March 3, 1958



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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OBSTETRICIAN-GYNECOLOGIST WANTED: Florida group desires obstetrician-gynecologist Board Certified or Board Eligible for permanent association. Guaranteed salary and percentage with advancement to full partnership. Will work with another Board Certified obstetrician-gynecologist. Position open July 1 or before. Write 69-270, P. O. Box 2411, Jacksonville, Fla.

GENERAL SURGEON: Florida license. Fifteen years surgical practice. Broad background Internal Medicine. Wishes to locate in Florida. Will associate. Write 69-272, P.O. Box 2411, Jacksonville, Fla.

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*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

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OBITUARIES

Percy Franklin Lisk

Dr. Percy Franklin Lisk of Fort McCoy died on Jan. 22, 1958, following a short illness. He was 76 years of age. Interment took place in the family plot in Ocklawaha Bridge Baptist Church Cemetery at Church Lake.

A lifetime resident of Marion County and prominent physician at Fort McCoy for 40 years, Dr. Lisk was the son of the late Dr. Benjamin F. Lisk and Susan Thomas Lisk, pioneer residents of Marion County. He was born at Connor on Sept. 16, 1881. He received his medical training at the Atlanta School of Medicine, which is now a part of Emory University, and in 1906 was a member of the first class to graduate from that

(Continued on page 116)



In a recent 140-patient study[1] DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

Robins

1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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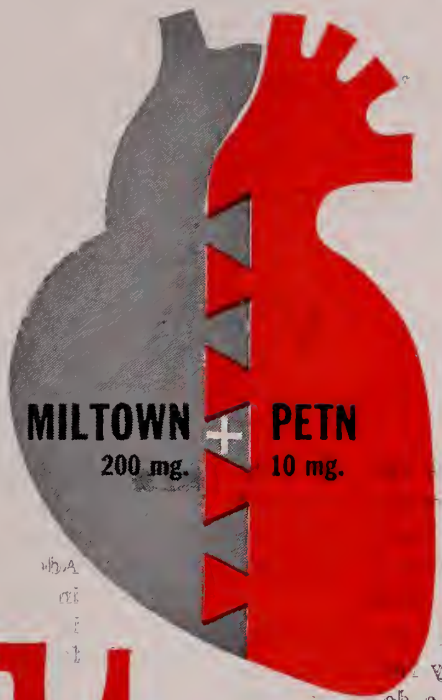
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The addition of Miltown to PETN, *as in Miltrate, "...appears to be more effective than* [PETN] *alone in the control of coronary insufficiency and angina pectoris."*[2]

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8:504, *Dec. 1957.*

NEW
dovetailed therapy combines in ONE tablet



Miltrate*

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prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

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sustained coronary vasodilation with **PETN** — pentaerythritol tetranitrate a leading, long-acting nitrate

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

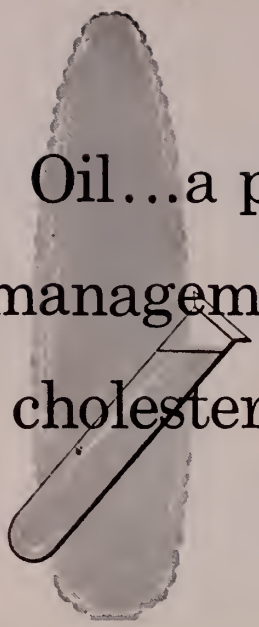
Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

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Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

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For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
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SCHERING

(Continued from page 111)

institution. Before entering medical school he completed a two year course in pharmacy.

Upon graduation, Dr. Lisk entered the practice of medicine at Fort McCoy and continued to practice general medicine in Marion County for four decades until ill health forced his retirement some years ago. Locally he was a member of Marston Lodge No. 49, F. & A. M., and of the Fort McCoy Baptist Church.

Dr. Lisk was a member of the Marion County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association.

Surviving are a sister, Miss Henrietta Lisk, of Fort McCoy; two daughters, Mrs. Susie Lisk Inman, of Manor, Ga., and Mrs. Louise Lisk Johnson, of Jacksonville; two sons, Lt. Col. Percy F. Lisk Jr., ROTC, Galesburg, Ill., and Alonson C. Lisk, of Ocala; and nine grandchildren. His wife, Mrs. Ola Howell Lisk, preceded him in death in 1926.

John Dupre Bell

Dr. John Dupre Bell of Pensacola met sudden death in that city on Jan. 28, 1958. He was 58 years of age.

A life-long resident of Pensacola, where he was born on Sept. 7, 1899, Dr. Bell received his early education locally. He then attended the University of Mississippi for his premedical training and the Tulane University School of Medicine for his professional training. He was awarded the degree of Doctor of Medicine by Tulane University in 1926. He served an internship with Drs. Newell and Newell of Chattanooga and a residency at the Chicago Lying-In Hospital.

Dr. Bell entered the private practice of medicine in his native city and engaged in the practice of obstetrics there for three decades. He was a member of the medical staff at the Sacred Heart Hospital, the Baptist Hospital, the Lady of Angels Hospital, and the Pensacola Maternity Hospital, where he also served as a trustee and was one of the founders. He was a member of the Navy League of Pensacola and the Pensacola Country Club. In his church affiliation he was a member of the First Presbyterian Church. His fraternity was Sigma Alpha Epsilon, of which he was a life member.

Serving his country with honor in three wars, Dr. Bell first saw service in World War I in the

*

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nephrosis

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hay fever

poison ivy dermatitis

urticaria

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Engineering Corps of the United States Army. In World War II and in the Korean conflict he was a member of the Medical Corps of the United States Navy, retiring with the rank of commander.

Dr. Bell was a member of the Escambia County Medical Society and for 31 years had held membership in the Florida Medical Association. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Helen S. Bell, of Pensacola; three daughters, Mrs. Raymond Dockum of Miami, Mrs. John O'Brien of Jacksonville, and Miss Cynthia Bell of Pensacola; two sisters, Mrs. Roland Lee and Mrs. Gladys Alford, both of Pensacola; one brother, Dr. James A. Bell of Pensacola; and one granddaughter, Miss Blanche Marie O'Brien of Jacksonville.

James Harold Mendel

Dr. James Harold Mendel died at his home in Coral Gables on Feb. 5, 1958, after a long illness with congestive heart failure. He was 63 years of age.

Born in Wheeling, W. Va., in 1894, Dr. Mendel attended schools there and received his medical training at Jefferson Medical College of Philadelphia, where he was awarded the degree of Doctor of Medicine in 1918. He then practiced otorhinolaryngology in Germantown, Philadelphia, and for 18 years taught neuroanatomy at his alma mater. Since 1936 he had practiced his specialty in Miami. He devoted 10 years of service to the ear, nose and throat department of Jackson Memorial Hospital and later was a clinical associate professor of otorhinolaryngology in the University of Miami School of Medicine. He was a founding member of the Greater Miami Eye, Ear, Nose and Throat Society. At various times he was an active member of the staff of every hospital in Greater Miami, but in recent years restricted his work to Mercy Hospital, where he organized the department of otolaryngology, and to Doctors Hospital. He was a member of the Riviera Country Club, the Rod and Reel Club of Miami Beach, the Miami Club, and the Elks Lodge of Coral Gables. His hobby was the growing of roses, and he was one of the founders of the Greater Miami Rose Society.

(Continued on page 124)

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'Cardilate' tablets  shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

*'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

For Speedier Return to Normal Nutrition

Meat...

and the Protein Depletion of Severe Infectious Disease

Recovery from severe infectious processes entails more than emergence from the effects of the causative agent. The semistarvation, the inactivity, the suppression of physiologic activity must all be corrected as rapidly and thoroughly as can be tolerated by the patient.

Return to normal nutrition can be speeded by an easily digested diet high in top quality protein and vitamin-mineral components.

Lean meat serves several purposes in such a program: It supplies easily digested protein of highest biologic quality for rapid re-establishment of nitrogen balance; it provides the gamut of B vitamins as well as certain minerals important to sound nutrition, and it brings appetite-stimulating flavor to meals, a consideration not to be underestimated in the psychic rehabilitation of appetite.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States



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for adults and children



Prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

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Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
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The ideal cerebral tonic and stimulant for the aged.



from confusion to a normal behavior pattern



NICOZOL relieves mental confusion and abnormal behavior patterns in your senile patients.

NICOZOL therapy will enable your senile patients to live fuller, more useful lives.

Mildy confused senile patients may be rehabilitated from public and private institutions and cared for in the home by sustained treatment with the NICOZOL formula.[1,2,3]

NICOZOL is supplied in capsule and elixir forms. Each capsule or ½ teaspoonful contains:
Pentylenetetrazol.....100 mg.
Nicotinic Acid..... 50 mg.

1. Levy, S., *J.A.M.A.*,153:1260,1953
2. Thompson L., Procter, R., *North Carolina M. J.*, 15:596,1954
3. Thompson, L., Procter, R., *Clin. Med.* 3:325,1956

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NICOZOL w/reserpine (0.25 mg.)
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Write for professional sample and literature

DRUG Specialties INC.

DRUG SPECIALTIES, INC.

WINSTON-SALEM N. C.

(Continued from page 118)

During World War I Dr. Mendel served as a medical officer in the United States Navy aboard the U. S. S. Pocahontas and in World War II was a selective service consultant in his specialty.

A member of the Dade County Medical Association, Dr. Mendel was also a member of the Florida Medical Association, the Southern Medical Association and the American Medical Association. He was a diplomate of the American Board of Otolaryngology and held membership in the Florida Society of Ophthalmology and Otolaryngology and the American Academy of Ophthalmology and Otolaryngology. In 1935, he was awarded a Bronze Medal by the American Medical Association for his exhibit on ear drums and later received similar recognition for this exhibit from the Southern Medical Association and the Florida Medical Association.

Survivors are the widow, Mrs. Kathleen Mendel, of Coral Gables; a daughter, Mrs. Dorothy Stanyon, of New York City; a son, Dr. James H. Mendel Jr., of South Miami; and a stepdaughter, Sandra Lynn Matter, of Coral Gables.



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Each tablet contains:

Vitamin A	8000 USP Units
Vitamin D	800 USP Units
Thiamin HCl	3 mg.
Ribaflavin	3 mg.
Pyridoxine HCl	1 mg.
Calcium Pantothenote	5 mg.

MULVITAB

Nicotinamide	20 mg.
Cobalamin (Vitomin B-12 Activity)	2 mcg
Folic Acid	0.25 mg.
Ascorbic Acid	75 mg.
Vitamin E (Alpho Tocopherol Acetote)	2 mg.

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Service Is Our Motto.

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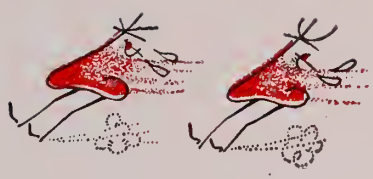
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running noses . . .



and other hay fever symptoms

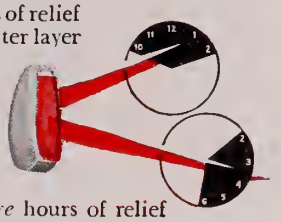
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

*Trademark

TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

Triaminic®

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WOMAN'S AUXILIARY

Report of the Annual Meeting of the Woman's Auxiliary to the Florida Medical Association

The 31st annual meeting of the Woman's Auxiliary to the Florida Medical Association met at the Americana Hotel, Bal Harbour, Florida on May 12th through May 14th with Dade County as Hostess Auxiliary.

The meeting was called to order at 9:30 a.m. with Judy Melvin, outgoing President, presiding for her last meeting. A welcome address was given with response, roll call, reports on the number of delegates, minutes read and the usual convention business. County Presidents were called upon to give their yearly reports.

Dr. Jere W. Annis of Lakeland, President-elect of the Association, brought greetings and gave a brief message stating that the Association appreciates and needs the support of the Auxiliary in helping them carry out their work. He made us feel more fully the importance of our work as Doctor's wives.

One of the highlights of the morning session was the presentation of Mrs. Walker Curtis of Atlanta, Georgia, President of Woman's Auxiliary of Southern Medical Association, who gave an address on "The True Meaning of Doctor's Day." She was introduced as a "Georgia Peach" and no better definition could be given. She radiates charm and personality and is the essence of true southern charm. She is most enthusiastic about her work in Southern Medical Association and it is impossible not to catch the spark when one listens to her talk. Truly a delightful address and well worth attending the convention if only to meet this interesting personality.

The final session of the morning brought us to the occasion when Mrs. Thomas C. Kenaston of Cocoa, Past President of the Auxiliary, installed Ann Rogers of Rockledge as President. It was fitting and touching that Polly should do this job as she was the first person who started Ann on the road in Auxiliary work on a state level.

The new President's address followed after the presentation of the gavel from Mrs. Melvin to the new President. A word of thanks from Judy was given for all who helped her in the past year's work. Her charm and quick wit always at hand makes presiding seem so easy for her.

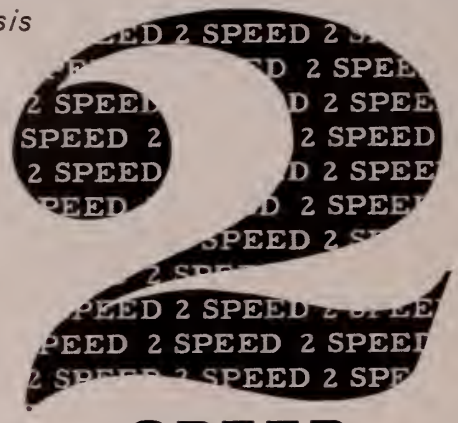
(Continued on page 134)

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Meta Cine represents a carefully designed formula which provides the physician with a vaginal douche preparation which safely and effectively maintains a clean healthy vagina.

Meta Cine is a combination of several ingredients clinically established as valuable in promoting proper vaginal hygiene. Diluted for use, Meta Cine possesses the desired pH (3.5); contains the mucus digestant, papain, which dissolves mucus plugs and coagulum; contains lactose to promote growth of desirable döderlein bacilli, and methyl salicylate for soothing stimulation of circulation within the vaginal walls.

Its pleasant, deodorizing fragrance also meets the esthetic demands of your patients.

Meta Cine is promoted exclusively to the medical profession, and recommends itself as your preparation of choice for patients who might otherwise indulge in unsupervised self-medication with potentially damaging nonphysiologic douches.

Supplied in 8-oz. containers. 2 teaspoonfuls in 2 quarts of warm water, douche as prescribed.

Printed douching instructions for patients available upon request.

BRAYTEN Pharmaceutical Company • *Chattanooga 9, Tennessee*

premenstrual

'DIURIL'

(CHLOROTHIAZIDE)

FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

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SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

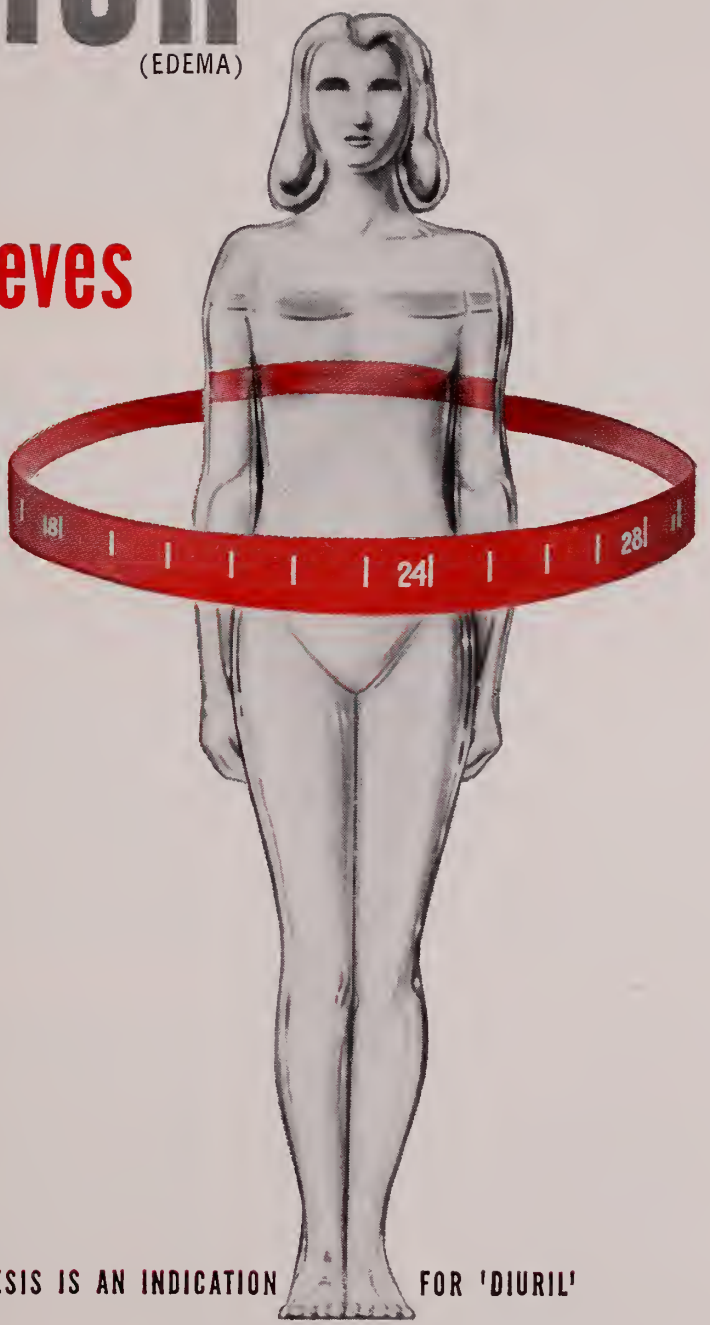
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Distress
Distention
Discomfort



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With a blender or an egg beater almost any food can be used

... and may we remind you that a glass of beer can make full-liquid diets more palatable?

The Full-Liquid Diet

● Strained chicken in milk makes "bisque"—in tomato juice it's "creole." Your patient may like cottage cheese whipped into milk flavored with chocolate and mint. Strained carrots go in milk flavored with nutmeg or pineapple juice. An egg or skim milk powder adds protein.

Strained fruits in fruit juices do well with a squeeze of lemon or a touch of mint. Bright colored drinks look good in clear glass—pale ones in gayly painted glasses.

Of course, only you can tell just which food your patient can have. And if you feel that a glass of beer* is acceptable in his specific condition, it may provide an incentive he needs to stay within the limits you set.

*pH 4.3; 104 calories/8-oz glass (Average of American Beers)

United States Brewers Foundation
Beer—America's Beverage of Moderation

If you'd like reprints of this and 11 other dietary suggestions, please write United States Brewers Foundation, 535 Fifth Avenue, New York 17, N. Y.

MY DAD— HE HURT HIS BACK REAL BAD

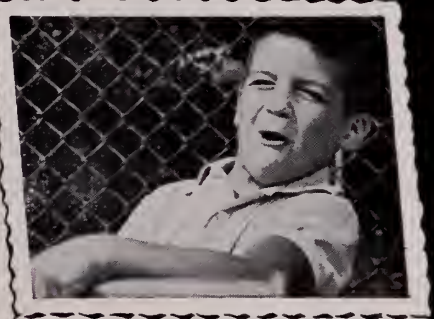
"It happened at work while he was putting oil in something"



"He told Mom his shoulder felt like it was on fire"



"He couldn't swing a bat without hurting"



"But Doctor gave him some nice pills--and the pain went away fast"



"Dad said we'd play ball again tomorrow when he comes home"



AND THE PAIN WENT AWAY FAST

FOR PAIN

Percodan®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) **TABLETS**

ACTS FASTER...
usually within 5-15 minutes

LASTS LONGER...
usually for 6 hours or more

MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

RARELY CONSTIPATES...
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New "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

Endo® **ENDO LABORATORIES**
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*U.S. Pat. 2,628,185

PMB-200

"Premarin" with Meprobamate new potency

Each tablet contains 0.4 mg. "Premarin," 200 mg. meprobamate

For undue emotional stress in the menopause

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Also available as PMB-400 (0.4 mg. "Premarin," 400 mg. meprobamate in each tablet).

Supply:
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CREMOSUXIDINE gives prompt control of seasonal diarrhea by providing antibacterial and antidiarrheal benefit. It detoxifies intestinal irritants and soothes inflamed mucosa.

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(Continued from page 126)

Tuesday morning, May 13th, the Post Convention Board and Business Meeting followed, new President Ann Rogers, presiding. Her well organized meeting showed she is off to a flying start for the year. She introduced her new board members and gave each an opportunity to ask questions to get the work rolling for the year.

A school of Instruction followed at 10:00 with Board members, District Chairmen, County Officers and Chairman present. Plans for the year were discussed, built around the national theme "Safe Guard Today's Health for Tomorrow." Phases of Auxiliary work recommended for priority this year are: A.M.E.F., Recruitment, Today's Health, and Safety.

State visitor to the morning session was Dr. Sam Day of Jacksonville, who is Secretary-Treasurer of the Florida Medical Association. He told some of the developments concerning the following: Blue Shield, Administration of Medicare, Florida Association Accident and Health Group Insurance Plan, Forand and Jenkins-Keogh Bill, New State Committee on Aged, Day of Orientation about Organized Medicine for all Medical Students and employment of doctors. Having a representative from the State Office was indeed a pleasure and offers a challenge to us to carry our share of medical work in the State of Florida.

The meeting was adjourned at 1:00 with a feeling of much being accomplished and the year off to a good start. Good-byes were said until this board will convene again in Daytona Beach in the fall.

Mrs. Albert F. Stratton Jr.

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Mrs. John P. Ferrell, Recording Secy.....*St. Petersburg*

BOOKS RECEIVED

Current Therapy 1958. *Latest Approved Methods of Treatment for the Practicing Physician.* Edited by Howard F. Conn, M.D. Pp. 827. Price, $12.00. Philadelphia, W. B. Saunders Company, 1958.

For the past 10 years the annual additions of this publication have brought to the practicing physician authoritative and current information on medical therapy. The 1958 volume offers immediate access to today's best therapeutic measures. For each of nearly 400 common diseases and disorders there is a concise but thorough description of the currently preferred treatment method. Written for quick reading and fast comprehension, the discussions crackle with practical facts and brisk instructions. Exact dosages are always given and prescriptions are written out when necessary.



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menopausal
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manages both the psychic and somatic symptoms
and *relieves* emotional stress in the menopause
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2-methyl-2-n-propyl-1,3-propanediol dicarbamate
Conjugated Estrogens (equine) .....0.4 mg.

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Each of 298 practicing authorities presents his most successful and effective method for managing a particular disease. These contributors have been carefully selected by an eminent board of consulting editors. In the opinion of the board each one is using the most effective treatment now known to medical science for the disease he writes about. More than a mere collection of recent advances, the book is a complete reference on treatment for virtually any disease encountered. This year's volume boasts many new treatments, but the old familiar standby is there, too, if it is still the best treatment. The criterion is effectiveness, not necessarily newness. One particular appeal of 1958 Current Therapy is that it removes any doubts the physician may have about whether or not there is some better treatment that he has perhaps overlooked. There are 227 treatments and articles which are new in this tenth annual volume.

Office Gastroenterology. By Albert F. R. Andresen, M.D. Pp. 707. Illus. 174. Price, $14.00. Philadelphia, W. B. Saunders Company, 1958.

This book is a compact guide to practical office technics for the diagnosis and treatment of digestive disorders. Particularly noteworthy are the physiologic approach to treatment, the emphasis on the importance of minor adjustments in the patient's diet, the simple presentation of medical aspects of diseases of the rectum and anus, the warnings on the dangers of indiscriminate use of antibiotics, tranquilizers, anticholinergics and corticosteroids, and the balanced attention given to x-ray and laboratory examination. In five sections the book covers a wide range of common problems: I. A Plan of Attack on Gastrointestinal Diseases: II. Diseases Affecting the Entire Gastrointestinal Tract; III. Diseases of Different Parts of the Gastrointestinal Tract; IV. The Liver and Biliary Tract; and V. General Diseases with Manifestations in the Gastrointestinal Tract. The author is Clinical Professor Emeritus of Medicine, State University of New York College of Medicine at New York City; Attending Physician, Long Island College Hospital; and Area Consultant in Gastroenterology, Veterans Administration.

Psychopathic Personalities. By Harold Palmer, M.D. Pp. 179. Price, $4.75. New York, Philosophical Library, 1957.

This study by a leading British psychiatrist presents the nature and character of the major mental disturbances, particularly schizophrenia and the manic-depression psychoses. The author observes in the Preface that the free world is not in danger from its good citizens, but from its hysterics, paranoiacs and psychopaths. How to recognize and control these psychopaths and how to understand the individual human aspect of tension are main problems of the Free World, and he seeks to portray the clinical aspects of this problem.

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Thiamine	1 4 mg
Riboflavin	2 4 mg.
Niacinamide	14 0 mg

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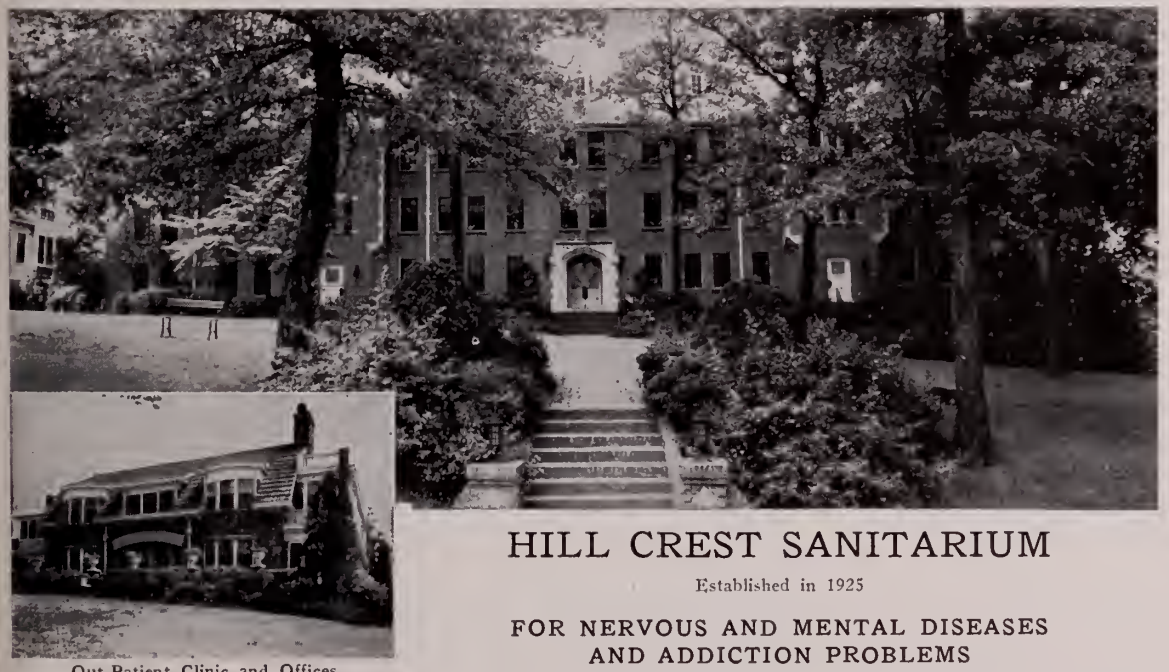
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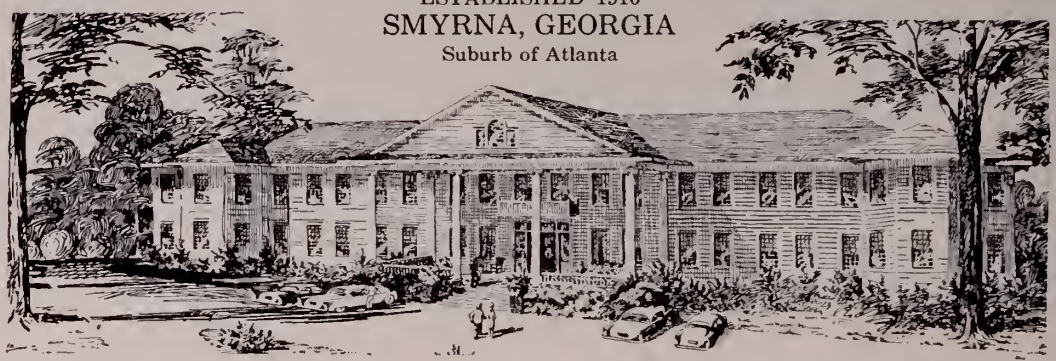
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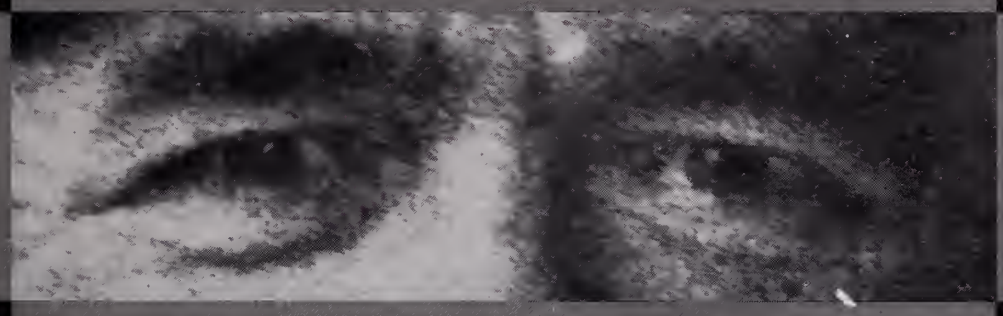
County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	2nd Tues.	31
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	1st Tues.	59
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	2nd Tues.	207
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	3rd Wed.	13
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	865
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	27
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	350
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	113
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	235
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	32
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	80
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	7
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	33
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	35
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	15
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	9
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	226
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Robert Y. Wheelihan, Riviera Bch.	4th Mon.	166
Pasco-Hernando-Citrus	S. Carnes Harvard, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	290
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	127
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	13
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Walter W. Weigel, St. Augustine	3rd Tues.	22
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	30
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	83
Seminole	Daniel H. Mathers, Sanford	Terry Bird, Sanford	2nd Tues.	17
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	7
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	94
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	30
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		5
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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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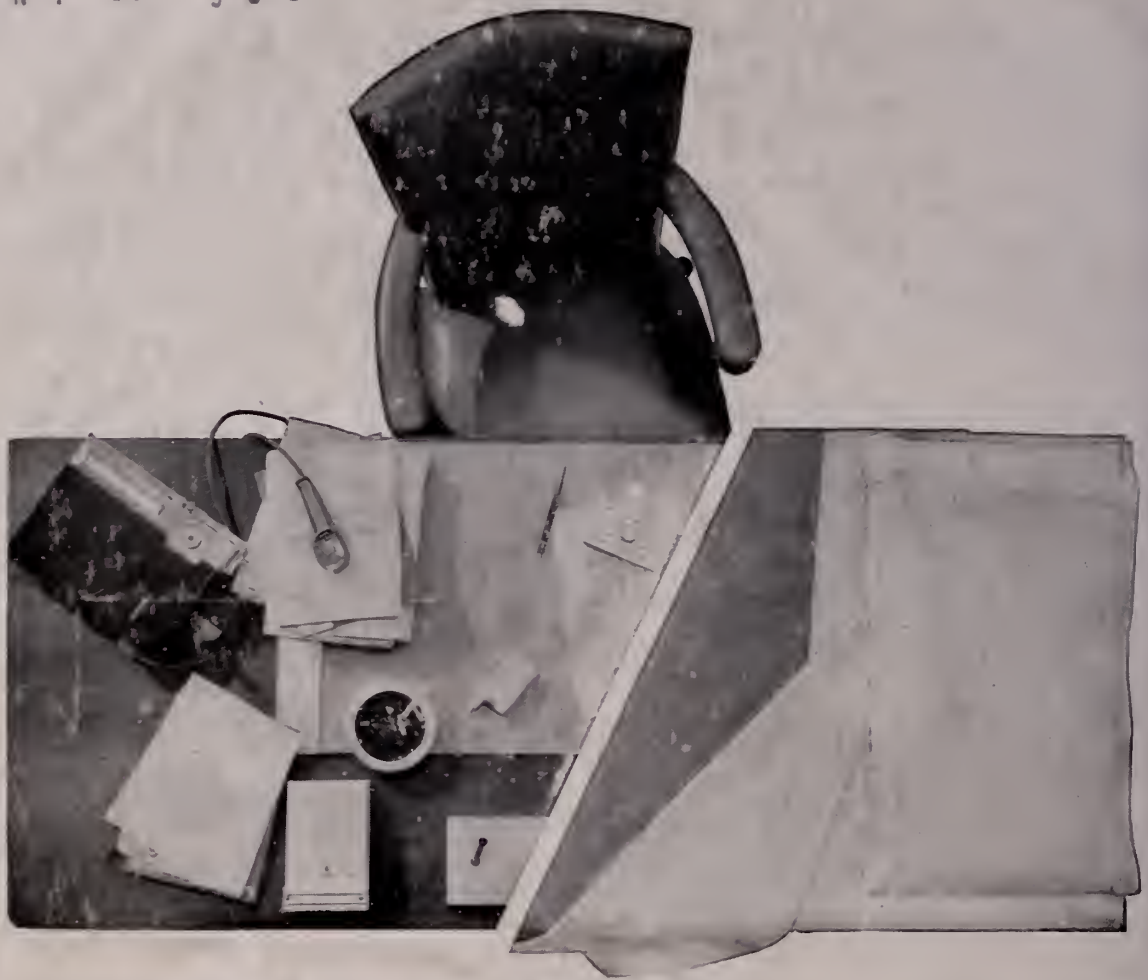
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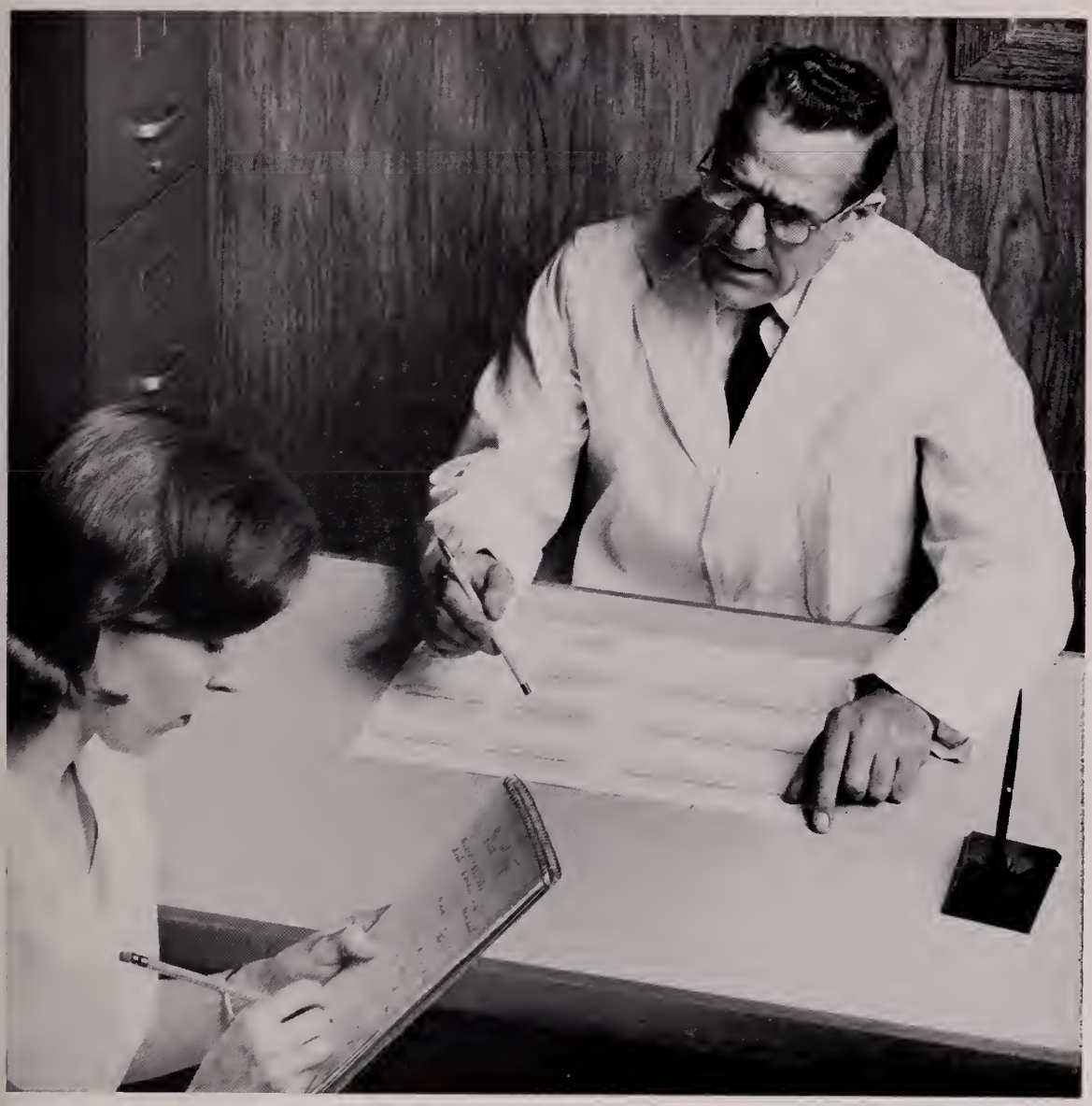
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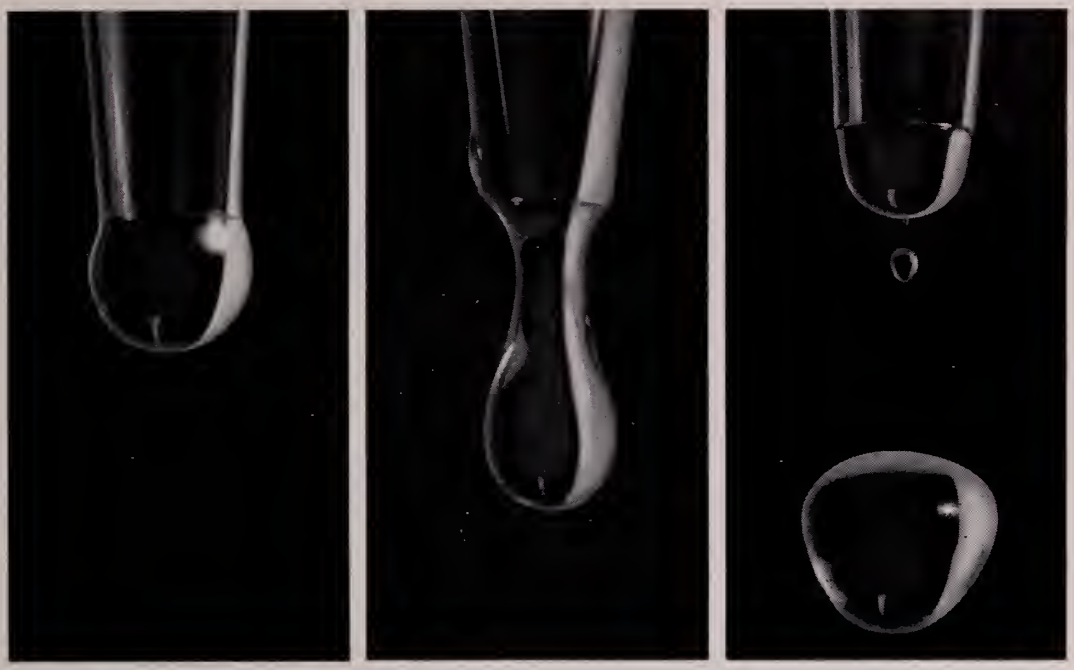
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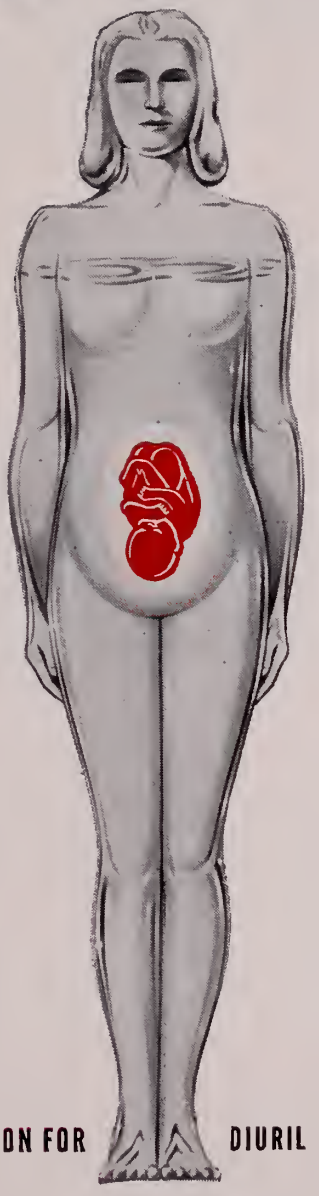
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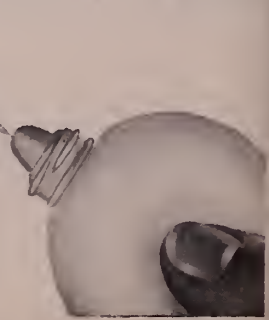
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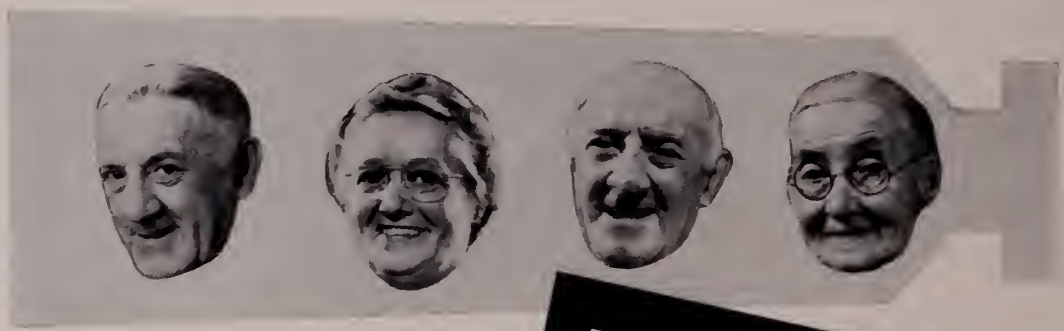
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The Greatest Problem of Medical Education And Its Relation To Medical Practice

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Medical education always has been and it is now beset with problems. In one respect at least it is like our political situation, especially our international situation—the present always is critical. I can recall when the crisis was the curriculum; after the curriculum was straightened out there were not enough students who were interested in medicine and, at the same time, qualified to pursue the improved curriculum successfully. Later we had an improved curriculum and a full enrolment, but we did not have the buildings to house the big enrolment. Currently the crisis—the biggest problem of medical education—is the faculty—a teaching staff sufficient in numbers and trained adequately to present the advanced curriculum successfully to the packed classes.

It seems that from the earliest times there have been a few—indeed a very few—men in all ages who have been so possessed by intellectual curiosity that they would forego gladly the usual comforts of life and the emoluments of temporal power if they were left free to study and to learn to stretch somewhat the bounds of knowledge and to encroach somewhat upon the vast area of the unknown. The enthusiasm of such men has quite universally led them to teach others to learn and to do so with little pay or none. In a society in which those only sought knowledge who wished to learn in order to satisfy intellectual curiosity and with no expectation of gaining wealth or power, the supply of teachers should never fail. The study of medicine today, however, is on quite a different basis.

There are still a few who study medicine because of intellectual curiosity. It may well be surmised that if these alone sought admission to medical colleges, the supply of teachers would be ample. The great flood of those who wish to study medicine have other motivations: they wish to relieve the sufferings of others and to have the satisfaction of the gratitude of those they have helped; they seek the social status of the benefactor of individuals and the leader in civic enterprises that improve the health and happiness of all; they wish to acquire new knowledge, not for intellectual satisfaction alone but to apply it to the betterment of mankind and the enhancement of the prestige and emolument of the discoverer; they wish to assure themselves and their families a much better than average income with a minimum of venture. These all are worthy motives and they produce together a host who seek medical training. The supply of teachers who teach because of the continued opportunities to learn and because they wish to train others in a field which they love is entirely inadequate. To secure enough teachers it is necessary to offer those who began the study of medicine with one or more of the motives enumerated, the expectation of a social status and a place in public esteem equivalent to that of the successful physician; the opportunity to develop new methods of diagnosis or treatment that will bring professional prestige and authority; and an income that will assure them and their families better than average financial means and security for the future.

Formidable Problem

This situation presents a formidable problem to all those interested in and dependent upon the maintenance of high standards of medical education. This is not limited by any means to the deans and professors of medical colleges. The entire medical profession is deeply involved. The esteem in which the profession is so widely held today has not always been so high nor have the emoluments always been so great. Time and again during the ages of recorded history the profession has achieved a similar status only to sink

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again to stereotyped procedures and quackery—Egypt, Greece, the Middle East will furnish apt examples.

If the present high status of the profession is to be maintained or, perhaps enhanced, medical research must be continued and enlarged in scope. The brilliant progress of medical knowledge in recent years has not only brought forth new methods of combating current diseases but also has given clear warnings against complacency. An antibiotic is brought out that is lethal to a common pathogenic organism. How painfully soon does a new strain of the organism appear that is resistant to the antibiotic! Then we must seek a new agent effective against the new organism. Children are protected against many of the infectious diseases of yesterday and their nutrition is so improved that they almost uniformly are physically stronger than their parents; yet now mental aberrations and disorders become matters of major concern to the pediatrician. Let medical research lapse for one generation and we shall find ourselves faced with medical problems as formidable as those of 1900 and without the resources to solve them.

Of course the greatest sufferer from a lapse of medical advance will be the public—the ultimate consumer and beneficiary of medical skill. Any deterioration in the medical profession is reflected immediately in an equal failure to protect the health and prevent the suffering and postpone the death of the people who cannot help themselves. The position, however, of the practicing physician without adequate information and without effective tools and skills will not be a happy one.

Role of the Medical Faculty

The overwhelming volume of medical research comes from the faculties of medical colleges. For all practical purposes the entire flow of basic research comes from these men or from the teachers of sciences ancillary to medicine. Nearly all of the applied research comes from medical faculties. It is only when we reach the developmental phase of research that pharmaceutical companies and industry play an important part in bringing new discoveries to physicians and to the public. A competent medical faculty in adequate numbers is absolutely essential to the continued growth of medical knowledge.

New medical knowledge and skills become effective only when their use becomes widely distributed among physicians. This may be hastened by medical journals and medical society presentations and postgraduate assemblies. The medium that surely puts the new material into medical practice is the medical college through the faculty. These men not only teach their undergraduate students and postgraduate students—they also provide most of the speakers for medical society programs and postgraduate medical assemblies. Medical college faculties not only discover most of the new information—they are also the mechanism for moving it from the laboratory and the hospital to the physician and the patient. No other factor so influences the progress or the retrogression of medicine and the physicians who practice it as the quality of the faculties of medical colleges.

The remarks and observations that I have made apply not only to the teachers of the clinical branches but equally to the preclinical teachers. Industry beckons to the chemist or the physiologist, drug manufacturers to the pharmacologists, hospitals to the pathologists. Indeed, the anatomist is the only teacher not subjected to constant temptation to change his course. Even this is not as true as it seems. A substantial fraction of those teaching anatomy are graduates in medicine. These are steadily changing to the practice of medicine. The University of Tennessee alone has lost three anatomists this year in this way. The number of men in training to teach anatomy has been diminishing for at least 10 years and the number entering the teaching field is now a trivial trickle compared with the urgent need for recruits. Today's recruits are embryologists, physiologists, zoologists. They are able men, but their first love is not anatomy. They teach anatomy of necessity and as a duty. This is a far cry from the inspiring and influential leaders in this field 50 years ago.

Need for Adequate Remuneration

What to do?

Obviously, a substantial increase in salary is part of the answer. I believe that if professors' salaries averaged between $20,000 and $25,000 annually, strong men could be held to the teaching profession. With such an income they could maintain for themselves and their families the place in community life which is open to successful physicians and lawyers and most successful business men. The salaries of the supporting staff should be proportional. Increase in salary alone

will not suffice—nor should it. Men of good quality do not strive greatly for their pay checks. They wish to have the respect and the admiration of their colleagues and of the general public as men successful in their chosen fields. In medical education this desire translates itself into opportunities for research. A reputation built upon successful teaching alone develops painfully slowly and is local and narrowly circumscribed. A reputation based upon research develops as rapidly as the energy and imagination and intelligence of the scientist uncovers new knowledge of significance and brings it to publication. Such a reputation is worldwide.

This is not to belittle the importance and the dignity of teaching. We must recognize, however, that research is one of the strong motivations that hold men in medical education. This fact is borne out by the experience of deans and department heads in their search for additional teachers. Men of good quality inquire most searchingly into the opportunities for research before raising the question of salary. Let it be understood at once that the conflict of research with teaching lies only in the proportion of time and energy devoted to each. Time and energy used in research cannot be used for teaching. The very qualities, however, that bring success in research almost uniformly result in good teaching. The productive scholar is intensely and penetratingly interested in his subject. This interest necessarily becomes a source of inspiration to his students and results as well in a deeper understanding of the subject matter by the students.

Research Facilities Essential

The necessity of providing research opportunities for both preclinical and clinical faculties results in a second current major problem of medical education—the significant enlargement of the physical plant. The research professor must have more than an office. He must have a laboratory other than those used by students. The size of the laboratory varies within wide limits. Almost uniformly assistants, highly trained themselves, are necessary. Frequently, extremely sensitive and complicated equipment is required and, together with it, personnel trained to use the equipment effectively. The space and equipment requirements of medical colleges are increased enormously by the development and expansion of medical research.

Clinical Contact with Private Patients

Adequate salaries and research opportunities are necessary to maintain satisfactory faculties, both clinical and preclinical. A third necessity develops in clinical departments. In these departments the teachers are not presenting the fundamental and background material such as characterize instruction in the preclinical departments, but rather they are teaching the diagnostic and therapeutic procedures and skills which the students expect to practice in the immediate future. Here is where the latest advances in medicine are introduced into the future practice of the students. In these circumstances the teacher's effectiveness and influence are enhanced greatly if he is known and respected as a successful practitioner of what he preaches—in other words, if he conducts a private practice on a high level. This necessarily has led to the wide use of the so-called geographical full time teacher. Such a teacher has his office and sees his patients in space provided by the medical college and adjacent to or part of the space available for teaching and research. The fraction of his energy and time devoted to private practice is limited by mutual agreement and by devices which vary from one college to another.

In a few institutions the full compensation of the teacher is paid by the college. The professor renders professional service to patients who come to him or to the university hospital to seek his help in the area in which he has developed extraordinary competence—a recently developed surgical technic or unusual ability in detecting and treating obscure medical or nervous disorders. Fees for such services are paid to the hospital or college. The advantage of this plan is that the teacher is freed from dependence upon income from patients and may devote himself single-mindedly to his teaching and research. At the same time his prestige with students and faculty is maintained and his personal contact with patients is continued. The chief disadvantage of the plan is that, while the teacher is freed from economic pressure, the administration of the college or hospital is subjected habitually to severe pressure to develop more income. Under the circumstances, there is considerable likelihood that too many patients will be accepted and assigned to the teacher so that he will not have as much time for research and teaching as might be hoped.

Under a second plan, the college pays the teacher a salary that is estimated to be from one half to two thirds of his total net income. The professor is expected to met his teaching obligations and to continue his research efforts vigorously. Income from his patients is paid to him directly, and his records are not subject to audit by the college. The advantages of this method are that the college assumes responsibility for only part of the teacher's income and has no incentive to impose increased patient service on the teacher. There is maximum flexibility as between patient service and college duties so that as pressure in one direction or the other develops, it may be accommodated. The fixed cost to the college is lower so that institutions hard pressed for funds, or in which the hospital is not owned by the college, may, nevertheless, be able to secure superior teachers. The disadvantage of the plan lies in its flexibility. In practice, the plan generally is satisfactory because the teacher and the administrator are men of good quality and manage the relationship in the best interest of teaching and research. In case of disagreement, however, neither the administrator nor the teacher has any support for his position except his personal judgment. Perhaps the plan also underestimates the pressure upon the teacher to increase his total income.

Probably the most widely used plan for the employment of full time teachers is one under which the college pays from one half to three fourths of the income and the remaining fraction is limited by prior agreement. This limit may be fixed by control of time limited to practice or by control of income received from patients. Obviously, the second method is more precise.

The advantages of this method are apparent. Both the teacher and the college enter into the agreement with clear understanding of what is expected of each. The teacher retains his contact with patients on the personal choice basis. His prestige as a teacher in applied medical practice is maintained both among his students and his staff associates. His total income is increased beyond the amount that the college could otherwise support.

The disadvantage of the method is that if the fraction of total income earned from private patients is high—say one half—the amount of time devoted to teaching and research may be too low. On the other hand, if the fraction is low—one fourth to one seventh—as in the University of Tennessee, either the total compensation may be too low to attract the best teachers or the cost to the college may be too high for its resources.

Under any plan of employing full time or geographical full time teachers, the extent to which the income of the teachers is derived from patients' fees constitutes competition with other physicians. The total of this competition when compared with the over-all competitive situation in medical practice is trivial indeed. When measured against the advantage to the profession of having strong medical colleges with able faculties continuing the advancement of medical knowledge and technics and disseminating this throughout the profession, there should be no hesitation in supporting the college programs.

Suffice it to say that the geographical full time arrangement helps to attract good men to teaching because it enables such a teacher to maintain and increase his prestige and influence with his colleagues in medicine and with the students he teaches; it gives him the professional satisfaction of serving people, his patients, and enjoying their grateful appreciation; and it increases his income beyond what the college's resources would afford.

Conclusion

In conclusion, a large number of teachers is necessary to train the students now enrolled in our medical colleges; the great majority of these teachers must find in teaching, emoluments equal to those immediately available to them in practice and in industry; to provide such emoluments salaries must be increased substantially, research opportunities must be available; and, in the case of clinical teachers, contact with private patients must be maintained.

62 South Dunlap Street.

The Treatment of Strabismus With Miotics

Thomas S. Edwards, M.D.
JACKSONVILLE

The treatment of strabismus is an ever changing problem. One of the latest changes involves the use of miotics as an adjunct to treatment as well as a new method of diagnosis. In the past five years there have been numerous reports and discussions of the use of miotics in this country, in Europe, and in South America.

There seems to be little doubt that these drugs are helpful. The question is how they aid in the treatment, which forms of strabismus are most likely to benefit from their use, and which of the drugs that produce the miosis are the safest and most efficacious. The miotics all act on the ciliary muscle, stimulating accommodation as well as producing the more obvious action upon the iris. Because of this local drug action accommodation is secured with little or no central accommodative innervation. Proportionally there is a lack of central convergence innervation. In this manner certain forms of convergent strabismus may be improved or completely cured. Obviously, miotics are of no use in a divergent squint.

Though this therapy is regarded as an innovation in treatment of squints, it was first introduced in the nineteenth century. Javal[1] reported in the 1890's using both pilocarpine and eserine for patients with convergent squints. He primarily used these drugs so that some of his patients could leave their glasses at home when they went to a wedding. It is sometimes surprising how little vanity changes over the years. In 1949 Abraham[2] reactivated this form of treatment with his report of using miotics in convergent strabismus.

Pharmacology

Before discussing the use of the drugs further, I shall first consider their pharmacology. Figure 1 gives an idea as to how the nervous stimulation to the ciliary body is effected and how it is affected by the various pharmacologic agents. A nervous impulse from the brain brings about the release of acetylcholine at the motor end plate so as to stimulate the action. The acetylcholine is then quickly neutralized by cholinesterase. This neutralization effects the usual short action of the nervous impulses. Physostigmine (eserine) and neostigmine (Prostigmin) are chemically similar to acetylcholine (fig. 2). Because of this similarity these two drugs act to inhibit the cholinesterase, but in a reversible combination. With the cholinesterase inhibited because of this combination the normal acetylcholine can stimulate the motor end plate without interruption for a period of time.

The next drug in line (fig. 1) is DFP (diisopropyl fluorophosphate). It is a markedly different type of chemical compound and combines with the cholinesterase irreversibly. The acetylcholine, therefore, can be active till more cholinesterase is brought from elsewhere in the body, or is manufactured locally. With this irreversible combination it is obvious why DFP is much more powerful and longer-acting than any of the other miotics.

Pilocarpine is the best known example of the third group of miotics. It acts like acetylcholine and stimulates the motor end plate directly. This stimulation, and consequent muscle spasm, last as long as the drug is present.

In summary, DFP irreversibly combines with and inhibits the action of cholinesterase, giving a long powerful action. Eserine and Prostigmin form reversible combinations giving a weaker shorter action, while pilocarpine stimulates the muscle directly.

Side Reactions

The various side reactions of the drugs are probably the most controversial and least understood of all the considerations. It is expected of all drugs that they may exhibit local and systemic allergic reactions. Knapp[3] using DFP, reported allergic reactions in three cases out of 316, or 1 per cent. Two were local reactions, and the third was an apparently allergic cough. Abraham[4,5] two were systemic nervous reactions of bed wet- also reported three allergic reactions in well over 300 cases. One was a local reaction. The other ting, nausea, and yawning in one patient and a nervous tic in the other, both of which cleared on stopping the drug. Malbran and Norbis[6] reported one case out of 109 in which DFP had to be stopped because of nausea and vomiting. In a series of 36 cases of strabismus in which pilocarpine was used in treatment, recently reported by me, in one patient hives developed and in an-

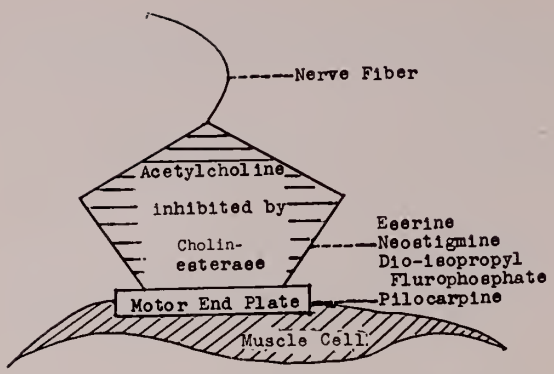
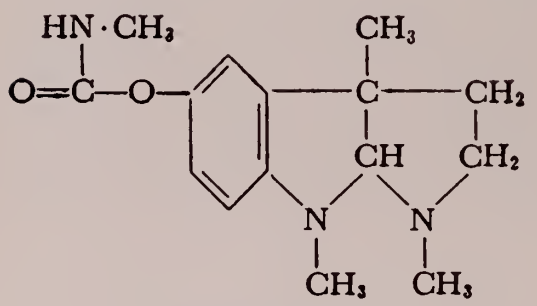


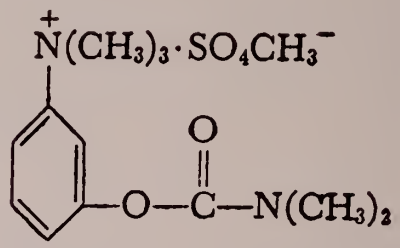
Fig. 1.—Diagram showing mechanism of miotics upon myoneural junction of the iris sphincter. Pilocarpine acts upon the motor end plate, while the others inhibit the cholinesterase.

other severe headaches developed.[7] Consequently, it can be seen that any of the miotics may cause allergic reactions in a small number of cases.

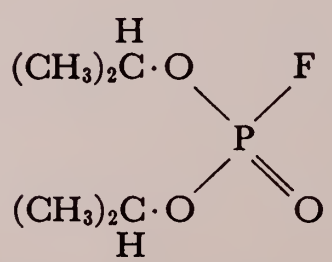
The other important side reaction of the miotics in general, and all of them may cause it, is iris cysts. These were first reported by Vogt[8] in 1920 when he noted cysts developing on both pilocarpine and eserine therapy in patients with glaucoma. These cysts are brown or chocolate colored bodies which appear, for some reason as yet unknown, along the pupillary edge of the iris, usually on the nasal side. Probably the best clinical study of this problem was carried out by Abraham,[9] who directed attention to them. Of the 66 cases he studied closely for the cysts, changes were evident in 42. These started in from one to 40 weeks, averaging 10 weeks. Usually, whenever the cysts were noted, the miosis was strong, whereas an active pupil was noted in those cases in which cysts did not develop. After cessation of the drops the cysts disappeared in from two to 42 weeks, with almost all cleared in 10 weeks. Only small, slender tags remained. He found no cysts in patients treated with pilocarpine and only a few in those treated with eserine or Prostigmin. Malbran and Norbis[6] reported that in 75 per cent of their cases of squint cysts developed while miotic therapy was employed. This figure is markedly different from the 4 per cent that Gerewitz[10] reported in his glaucoma patients. The eyes of children, therefore, must respond differently from those of adults. Knapp[3] also noted the cysts in the eyes with nonmobile pupils. He was of the opinion that on his



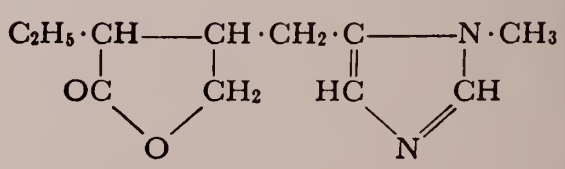
Physostigmine



Neostigmine Methylsulfate



Diisopropylfluorophosphate (DFP)



Pilocarpine

Fig. 2.—Chemical formulas of major miotics.

regimen, which will be discussed later, in no case have iris nodules of significant proportions developed and in only a few have nodules developed of even small proportions.

What are these cysts, or nodules, and how are they caused? One can only say frankly that the answer is not known. It was originally thought that the cysts were caused by the immobilization of the iris against the surface of the lens following a definite and prolonged miosis. It was believed that this caused serous fluids to separate the two layers of the pigment epithelium on the posterior surface of the iris forming the cysts. This origin was questioned when Christensen, Swan and Huggins[11] studied two eyes with these cysts, one pathologically. In one patient with congenital aniridia and secondary glaucoma, under miotic therapy two typical pigmented nodules developed at the border of the rudimentary iris. As the iris was immobile, miosis could not have been a factor in this case. They also studied the eye of a nine year old boy with congenital glaucoma whose eye was enucleated after these cysts developed because a tumor was feared. In this case there was a proliferation of the pigment epithelium with the formation of mostly solid nodules rather than cysts. Further, the cysts were filled with a pigment-permeated fluid and not the clear serous fluid previously supposed. Also, there was a new growth of the iris pigment layer beyond its normal borders, an actual hyperplasia possibly bordering on a neoplasia. Obviously, there is much yet to be learned of these cysts, and of their long term course.

Treatment

From the facts presented on the pharmacology it is evident that these drugs are primarily effective when the accommodation-convergence ratio is upset with a consequent esophoria or esotropia. They have also been used as a diagnostic tool to save the expense of a trial on glasses.

Abraham[4] used the miotics for treatment and reported in 1952 on 132 cases of convergent strabismus. In 109 cases in which the strabismus was intermittent or periodic, 87 per cent of the patients were helped. In the 23 cases in which it was constant, 11 or 48 per cent were helped. Malbran and Norbis[6] reported similar results. They found improvement in 71 per cent of the accommodative esotropias, 81 per cent of the partially accommodative, and only 40 per cent of the non-accommodative types. Knapp[3] compared DFP and the use of glasses as forms of treatment in 123 cases. He concluded that DFP was a better form of treatment than glasses in 10 per cent of the cases and equal to glasses in 78 per cent of the cases. This author also used the drug as a diagnostic aid in 126 cases. In these it was desired to eliminate the accommodative element of the esotropia before deciding upon further therapy. Jonkers[12] in Europe also used the drug in a similar manner and concluded that miotics are of great diagnostic importance while their therapeutic effect is not too great.

In my series of 36 patients in a clinic practice treated with pilocarpine, one fourth improved on the pilocarpine therapy and the remainder showed little or no improvement.[7] Eight of those without improvement stopped the drops for various reasons such as headaches, hives, and mostly parental indifference. Of the nine who did improve, all used 2 or 4 per cent pilocarpine at least three times a day for a period of two or more weeks. It was concluded that good results can be obtained with pilocarpine if the patient will continue the frequent use of the drops. In some cases, however, in which this drug is not entirely adequate, Abraham[4] suggested changing the medication to DFP. In his series of 132 cases, 10 patients who were not helped by the pilocarpine therapy were improved when DFP was substituted.

What then does the best regimen seem to be? Knapp[3] suggested using the DFP drops in each eye nightly for two weeks as a diagnostic aid. These drops are locally diluted to 0.025 per cent solution with peanut oil U.S.P. After the two weeks the patient is then re-examined. If there has been little or no reduction in the deviation, the accommodative component is regarded as minimal. If, however, there has been an improvement in or elimination of the deviation, the miotic is then continued for two months at a frequency of every other night. In the cases in which this frequency has not succeeded, miotics have been stopped and glasses instituted. According to Knapp,[3] this regimen has produced no nodules of significant proportions.

In view, however, of the danger of producing any nodules at all, it seems that a slight modification of the regimen might be indicated, considering the successes that Abraham[4] and I[7] have separately reported with pilocarpine. After the initial diagnostic trial with DFP for two weeks, the patient could then be treated for two months with pilocarpine four times a day. If this therapy

is not successful, one could always return to the use of DFP every other night, or even every night, temporarily, always, of course, realizing that one is taking a slight chance that the few small nodules might become dangerous at some future date. Also, if one did not want to use DFP, the patient could be treated with glasses.

Conclusion

Miotics have proved of great benefit in accommodative convergent strabismus, both diagnostically and therapeutically. Probably the diagnostic use will prove to be of more importance in the long run than the therapeutic use, especially since the patients can be successfully treated by wearing the full cycloplegic correction, by bifocals, or by orthoptic training. Probably the miotics will be most useful therapeutically for temporary cosmetic improvement to permit the patient to remove his glasses for a limited period of time.

In summary, all of the miotics have a place in the diagnosis and treatment of strabismus. DFP is by far the most powerful, consequently much better for diagnostic use. The great strength of DFP, however, and the consequent side effect of iris cysts make it desirable to use other drugs, whenever possible. The occurrence of the iris cysts and pigment epithelium metaplasia must be studied further before they can be dismissed as insignificant tags.

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Total Anomalous Pulmonary Venous Connection

A Case Report

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Total anomalous pulmonary venous connection has become a subject of increasing interest in the literature during recent years as a result of advances in cardiac surgery and newer technics in the diagnosis of cardiac malformation. Nevertheless, the existence in the literature of only approximately 100 proved cases attests to the relative rarity of this congenital lesion. The pathology and embryology of anomalous pulmonary veins have been discussed elsewhere[1-3] and will not be included in this report.

Patients with total anomalous pulmonary venous connection rarely survive to reach adulthood. Eighty per cent of the patients in the 58 cases collected by Keith, Rowe, Ulad and O'Hanley[4] died within the first year of life. The literature records 15 cases in which the patient survived past the age of 20.[1,4,13] The purpose of this case report is to present the clinical and physiologic data in an adult male aged 27 years. The only patients older than the present one were five women of ages varying from 28 to 45 years,[1,7,9,12] and one man of age 28.[7]

Report of Case

A 27 year old white man stated that he was born a blue baby; a diagnosis of congenital heart disease was made at that time. He has had clubbing of the fingers and toes as far back as he could remember. Between the ages of six and 12, on moderate exertion he experienced slight cyanosis and dyspnea, which were relieved by assuming a squatting position. During this period digitalis was administered. A spontaneous improvement in his condition occurred in the period between the ages of 13 and 17; cyanosis and dyspnea rarely occurred. Since the age of 18, cyanosis and dyspnea on exertion have become more frequent and gradually more disabling. He has been employed in various positions involving only sedentary work since 1951.

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During the past three years, symptoms have increased markedly. Cyanosis is now present at rest, and fatigability and dyspnea are present on minimal exertion. Appetite has decreased, and he has lost 30 pounds. There have been occasional bouts of palpitation, as well as attacks of sharp, knifelike precordial pains associated with hyperventilation. During the past year, paroxysmal nocturnal dyspnea has occurred on several occasions. Neither peripheral edema nor ascites have ever been noted.

In January 1956, the patient underwent cardiac catheterization at another institution. He was found to have moderate pulmonary hypertension as well as a bidirectional shunt. He was advised to return for a repeat catheterization, but did not do so.

In July 1956, the patient was hospitalized for another bout of knifelike precordial pain. Physical examination revealed a thin white man who appeared to be chronically ill. The blood pressure was 100 systolic and 70 diastolic. The pulse rate was 78 and regular. The respiratory rate was 18. The temperature was normal. The nailbeds and ear lobes were cyanotic; pronounced and equal clubbing of the fingers and toes was noted. The conjunctivae were suffused. The neck veins were flat. The anteroposterior diameter of the chest was moderately increased. The lungs were normal on auscultation and percussion. The heart was grossly enlarged to percussion, and the point of maximum impulse was in the sixth intercostal space beyond the midclavicular line. There was a palpable heave in the left parasternal area. M_1 was louder than M_2, and P_2 was louder than A_2. All sounds were split. A loud systolic murmur associated with a thrill was maximal in the pulmonic area. A short, faint, high-pitched diastolic murmur was heard at Erb's point. Rhythm was regular. No gallop or rub was present. The liver was palpable 1 cm. below the costal margin. All peripheral pulses were palpable, and there was no edema. The remainder of the physical examination was normal.

The hematocrit was 57 per cent, the red blood cell count 5.5 million, the white blood cell count 7,400 with a normal differential count, and the hemoglobin 17.4 Gm. The V. D. R. L. was nonreactive.The urinalysis was normal. The electrocardiogram (fig. 1) showed pronounced right ventricular hypertrophy. This was confirmed by a vectorcardiogram. Fluoroscopy revealed extensive bilateral pulmonary congestion extending to the periphery, and a decided hilar dance. The pulmonary artery segment, right atrium and right ventricle were greatly enlarged. The left atrium and left ventricle were not enlarged. The aorta was in normal position. A roentgenogram of the chest (fig. 2) showed, in addition, an increased density in the region of the superior vena cava.

During this period, two cardiac catheterizations were performed. During the first study (table 1), the left to

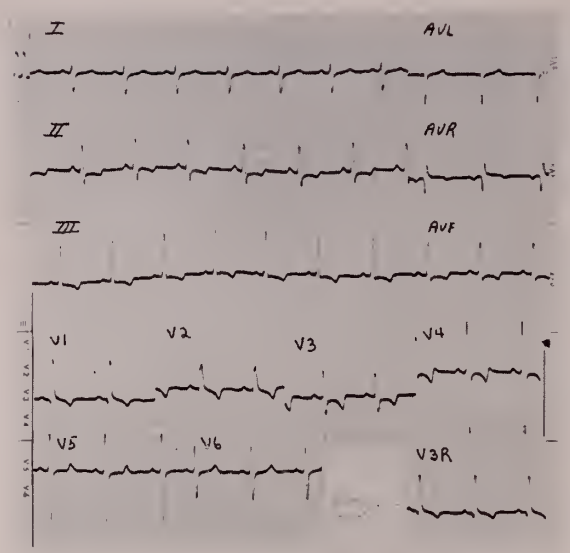


Fig. 1. — Electrocardiogram: The changes are those seen in right ventricular hypertrophy with right axis deviation; a qR pattern in the right precordial leads with inverted T waves; and an equiphasic RS pattern in the left precordial leads.



Fig. 2. — Posteroanterior Chest Roentgenogram: The pronounced pulmonary hyperemia, enlarged pulmonary arteries, and gross cardiac enlargement are readily seen.

right shunt was estimated to be 80 per cent using the nitrous oxide method (table 2).[14] Moderately severe pulmonary hypertension at rest was noted together with a minimally elevated right ventricular end-diastolic pressure. The right atrial pressure at the "Z" point was also minimally elevated. During the course of the second catheterization (table 3), it was possible to manipulate the catheter tip so that it passed through an interatrial septal defect into the left atrium and then into the left ventricle (figs. 3 and 4). The pressure in the left atrium and the end-diastolic pressure of the left ventricle were probably within normal limits based on experience with right and left simultaneous combined cardiac catheterization[15] in patients with rheumatic heart disease (fig. 5).

Following his discharge after this admission, he was hospitalized again on five different occasions for short periods of time because of hyperventilation syndromes. He then returned to his home in another state pending arrangements for cardiac surgery.

Discussion

The data from the first catheterization clearly indicated the existence of total anomalous pulmonary venous drainage because of the similar oxygen content of the blood in the superior vena cava, right atrium, right ventricle, and the brachial and femoral arteries. A second catheterization was performed in order to define more exactly the location of the anomalous pulmonary venous connection. These two studies indicated that the site of anomalous pulmonary vein connection was in the distal part of the superior vena cava or the adjacent portion of the left innominate vein. It is thought that the higher oxygen content of the inferior vena cava blood as compared to the innominate vein blood can best be explained by nonuniform mixing and by a sampling of laminar flow of renal vein blood in the inferior vena cava rather than by a subsidiary pulmonary venous connection to the inferior vena cava, although the possibility of the latter is not completely ruled out.

The interatrial septal defect, demonstrated by passage of the catheter through the defect, represents the only means by which blood from the pulmonary circulation can gain access to the systemic circulation. Survival is usually impossible in the absence of this lesion. The arterial unsaturation is due to the mixing of fully saturated pulmonary venous blood with unsaturated systemic venous blood in the superior vena cava and right atrium. The pulmonary flow is of necessity greater than the systemic flow, and therefore the arterial oxygen saturation is not markedly reduced and may even be as high as 93 per cent.[5,7] For this reason pronounced cyanosis is not a common feature of the clinical picture in many of the patients with this anomaly. Transient cyanosis has occurred occasionally immediately after birth, and almost all patients become cyanotic terminally. As the pulmonary artery pressure rises, it is probable that the pulmonary blood flow decreases. Mixing of unsaturated systemic venous blood with a decreasing volume of

Table 1

		Oxygen Content (Vol. %)	Oxygen Capacity (Vol. %)	Oxygen Saturation (Vol. %)	Pressure (mm. Hg.)
Pulmonary capillary					6
Right brachial artery		22.4	27.0	82	110/70,85
Right brachial artery	a	22.7	26.8	86	
Right femoral artery	a	22.5	26.8	85	110/60,74
Right brachial artery		22.0	26.6	84	
Right femoral artery	a	21.9	26.6	83	
Right pulmonary artery	a	23.2			70/29,41
Main pulmonary artery		22.7			
Outflow right ventricle		22.5			
Mid right ventricle		22.7			70/6
Tricuspid right ventricle		23.1			
Tricuspid right atrium		21.9			2[b]
Superior vena cava		24.0			
High right atrium		23.0			
Low right atrium		23.5			
Right brachial artery	c	24.0	26.9	91	
Right femoral artery	c	23.7	26.9	89	

a. Samples are drawn simultaneously.
b. "Z" point equals 6 mm. Hg.
c. Samples drawn after breathing 100 per cent oxygen for 10 minutes.

saturated pulmonary venous blood results in greater systemic arterial unsaturation and ultimately the appearance of cyanosis.

Tracings of intracardiac pressures are helpful in evaluating the possibility of coexisting congenital abnormalities. In this case, analysis of the pressure curves excluded the diagnosis of an Eisenmenger complex. The right ventricular pressure was significantly lower than the brachial artery pressure, whereas in the Eisenmenger complex these pressures are equal or nearly so because of the presence of an overriding aorta.

The electrocardiogram demonstrated the typical findings of right ventricular preponderance

Table 2. — Nitrous Oxide Study

Site	N_2O Content * (Vol. %)
Left brachial vein	0.18
Right pulmonary artery	2.21
Right brachial artery	2.70

$$\text{Left to right shunt} = \frac{\text{RPA} - \text{RBV}}{\text{RBA} - \text{RBV}} = 80\%$$

*Integrated samples drawn simultaneously over a one minute period while the patient is breathing a special gas mixture (N_2O 15 per cent; O_2 21 per cent; N_2 64 per cent. An increase in nitrous oxide content in the pulmonary artery compared with the brachial vein sufficient to result in a value of 32 per cent or more when using this formula is considered diagnostic of a left to right shunt.[14]

Table 3

		Oxygen Content (Vol. %)	Oxygen Capacity (Vol. %)	Oxygen Saturation (Vol. %)	Pressure (mm. Hg.)
Pulmonary capillary					5
Right brachial artery	a	18.9	23.3	82	115/66,83
Right pulmonary artery	a	20.1			63/28,38
Main pulmonary artery		19.4			
Outflow right ventricle		19.4			
Mid right ventricle		19.1			
Tricuspid right ventricle		19.4			66/6
Tricuspid right atrium		19.3			4[b]
Low right atrium		16.4			
Left atrium		18.6			101/12
Right brachial artery	a	19.0			7[c]
Left ventricle		19.0	23.6	82	
Low superior vena cava [d]		21.1			
High right atrium		21.0			
Mid right atrium		20.8			
Inferior vena cava		15.4			
Low right atrium		21.4			
Superior vena cava [e]		20.3			
Superior vena cava [f]		18.4			
Left innominate vein		9.9			
Superior vena cava [e]		19.5			
Right brachial artery		18.9	23.6	81	

a. Samples were drawn simultaneously.
b. "Z" point equals 6 mm. Hg.
c. "Z" point equals 11 mm. Hg.
d. Just above junction with right atrium.
e. Two inches above junction with right atrium.
f. Three and one-half inches above junction with right atrium.



Fig. 3. — Posteroanterior Spot Film During Cardiac Catheterization: The tip of the catheter is passed from the right atrium, through an interatrial septal defect, into the left atrium and thence into the left ventricle.



Fig. 4. — Left Anterior Oblique Spot Film During Cardiac Catheterization: The tip of the catheter has traversed the same pathway as described in figure 3.

with a qR complex in the right precordial leads. These electrocardiographic findings were also observed by Keith and his associates[4] in 13 of his 14 cases.

Murmurs may be absent; however, in most cases a systolic murmur can be heard in the second, third, and fourth left intercostal spaces near the sternum.[4] Apical and pulmonic diastolic murmurs[3] and continuous pulmonic murmurs have also been described.[4]

Roentgenograms of the chest and flouroscopy generally reveal evidence of enlargement of the right atrium and right ventricle, prominence of the pulmonary artery segment, aortic hypoplasia, increased pulmonary vascularity, and frequently a hilar dance. The "figure-of-8" configuration of the mediastinal shadow[16] is probably pathognomonic of anomalous pulmonary venous connection into a persistent left vertical vein with oxygenated blood returning to the right atrium via an enlarged left innominate vein and superior vena cava. A "boxlike" appearance of the heart in the posteroanterior position is also frequently seen,[1] and is due to massive enlargement of the right atrium and ventricle with clockwise rotation of the heart. Angiocardiograms may reveal a

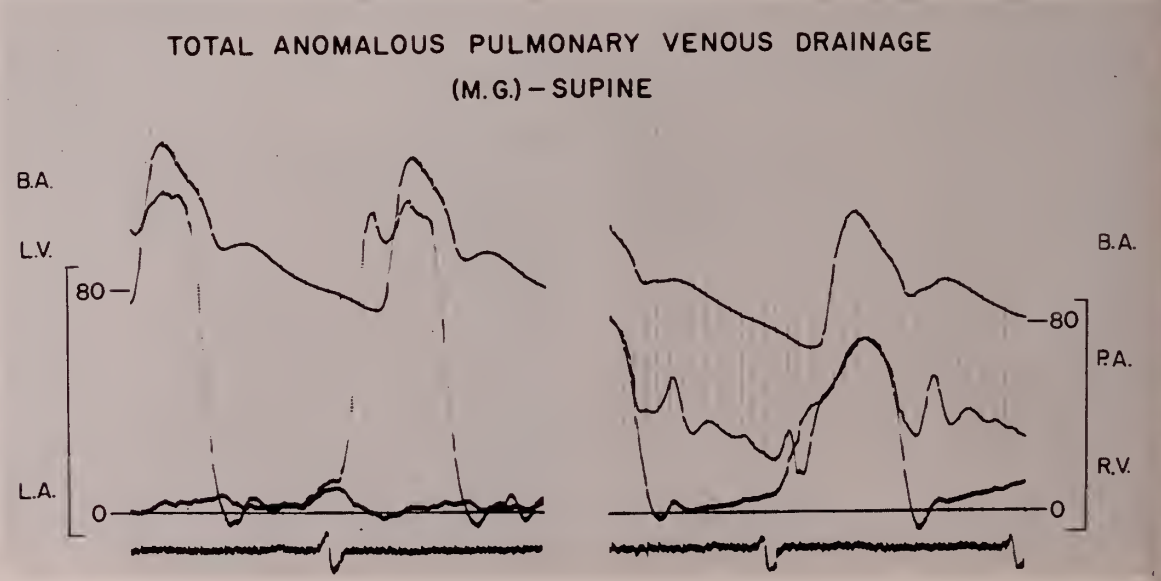


Fig. 5. — A. Left Side: Brachial artery, left ventricle, and left atrial pressure curves recorded from the same baseline and at identical sensitivities. Left ventricle and brachial artery systolic pressures are similar. The brachial artery systolic pressure is higher because of the physiologic increase in systolic pressure in the peripheral arteries as compared to the central aorta and left ventricle. The electrocardiogram is below.

B. Right Side: Brachial artery, right ventricle, andpulmonary artery pressures recorded from the same baseline and at identical sensitivities. The difference in brachial artery and right ventricular systolic pressures is readily appreciated.

localized dilution of the opaque material in the superior vena cava caused by a jet of pulmonary vein blood,[1] or an enlarged right atrium may be seen with simultaneous opacification of the pulmonary artery and aorta, the latter filling from the left side of the heart.[16]

Cardiac catheterization reveals a decided increase in oxygen saturation of the blood in the superior vena cava or right atrium (or elsewhere, depending on the site of the connection); the saturation then remains constant throughout the remainder of the right atrium, right ventricle, and pulmonary artery. The pulmonary arterial oxygen saturation is approximately equal to the systemic arterial saturation. Moderate pulmonary hypertension is frequently noted. Furthermore, the catheter tip often can be made to pass through the atrial septal defect or directly into the anomalous pulmonary vein.

The rapid developments in the field of cardiac surgery indicate that an ever increasing number of patients with congenital heart disease can be helped. Successful attempts at surgical correction of total anomalous pulmonary venous drainage have thus far been few.[1,13] The surgical approach to this lesion, however, will be facilitated by the availability of cardiac bypass pumps which will permit open heart surgery under optimal conditions. Therapeutic successes will depend upon the establishment of an accurate anatomic diagnosis as early as possible during the life of the patient.

Summary

A case of total anomalous pulmonary venous connection and drainage with complete cardiac catheterization data is presented. The clinical picture, including radiographic signs and physiologic data, is briefly reviewed.

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Treatment of Dermatoses With Thorium-X

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There have been several reports in the recent literature concerning the treatment of skin diseases with Thorium-X. Among the recent articles are those of Lewis, Frumess and Henschel.[1] Van de Erve,[2] Mackey,[3] Corsi,[4] Pinkus[5] and Hendren and Pinkus.[6] The present report deals with my experience with the use of Thorium-X in the treatment of patients suffering from chronic inflamatory dermatoses, warts and angiomas.

Thorium-X is a natural radioactive isotope of radium emitting alpha rays which represent about 95 per cent of its total energy. It has a half life of 3.65 days. The alpha particles penetrate tissue to a depth of 0.08 mm. Witten and Sulzberger[7] have demonstrated activity in sweat glands as deep as 1.8 mm. below the surface of the skin. This penetration is largely through the hair follicles and sweat ducts and is not diffused through the tissue. Since alpha particles can be stopped by a thin sheet of paper, all scales should be removed from the skin surface before application. Faint erythema appears in 24 hours and may deepen, depending upon the concentration used. This is often followed by pigmentation, which slowly disappears.

Analysis of Series

There were 29 cases in which patients were treated with Thorium-X. In two cases verrucae vulgares in the periungual and subungual areas were present; in seven plaques of guttate psoriasis, in three plaques of nummular eczema, in seven localized plaques of neurodermatitis, in three pruritus ani, vulvae and scroti, in one lichen planus, in four hemangiomas, in two varicose ulcers, in one chronic paronychia and in one psoriasis of the finger nails and toenails. The warts disappeared in both cases after three applications of Thorium-X, applied one week apart. In the case of localized patches of lichen planus on the ankles and left shin, two applications were made, and the lesions healed within one month. Definite improvement and regression were noted in the cases of pruritus ani, vulvae and scroti with a noticeable diminution of the associated itching; however, the effect was only temporary, and the itching returned after six weeks. There was a definite improvement in all of the cases of localized patches of neurodermatitis. In some the response was remarkable, and in the others there was a fair to moderate improvement; however, the itching was diminished in all cases.

There was a moderate to pronounced improvement in the three cases in which nummular eczema was treated with Thorium-X. Also, there was a moderate improvement in all cases of guttate psoriasis after four treatments had been given. No improvement, however, was noted from this therapy in the two cases of varicose ulcers or in the cases of onychomycosis of the fingernails and toenails, paronychia and psoriasis of the nails. It was of definite value as an adjunct treatment for angiomas of the hypertrophic strawberry type and it was an excellent method for treating outlying islands of hemangiomas left over after deeper therapy. It produced less scarring than the conventional carbon dioxide snow, which is usually used.

Technic

Although Thorium-X can be applied in an ointment base, lacquer or alcohol, in this series alcohol was used exclusively as a vehicle. The usual strength applied was 225 micrograms per cubic centimeter, 1 cc. being sufficient to cover an area approximately the size of a palm. Three separate applications were made one minute apart. The area was then covered with collodion for three days, after which the patient was instructed to remove the collodion with alcohol or acetone. The next treatment was given according to the reaction obtained after the first treatment. On the average, about three treatments were given, anywhere from a week to six weeks apart.

Conclusion

Thorium-X emits almost pure alpha radiation, which gives it a high margin of safety. It is particularly valuable in superficial dermatoses when irradiation is indicated, either as a primary method or as an adjunct to other therapy, and is of value in the treatment of psoriasis, localized plaques of neurodermatitis, nummular eczema, angiomas and warts. It is of lesser value in the treatment of pruritus ani, vulvae and scroti and of no value

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in the treatment of onychomycosis, paronychia and varicose ulcers.

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Report on Cat Scratch Disease

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The purpose of this paper is to direct attention to a rather common disease, especially in this part of the country. Cat scratch disease should be thought of in every case of localized lymphadenopathy. In the Journal of the Florida Medical Association Blinski and Kaye[1] from the Miami area reported two cases in December 1955, and DeVito[2] reported four cases from the St. Augustine area in March 1954. Four additional cases are here reported.

It is also the intention to point out that the diagnosis of cat scratch disease is simple to make, requires little time and expense, and may obviate the need to perform some relatively expensive and painful diagnostic studies in the work-up of cases presenting lymphadenopathy.

Cat scratch disease is a specific infection of unknown cause, believed to be viral, characterized by regional lymphadenopathy, sometimes proceeding to suppuration. It is preceded by a primary cutaneous lesion or scratch inflicted by a cat in about 50 per cent of the cases. In the literature it has also been referred to as nonbacterial regional lymphadenitis or benign lymphoreticulosis of inoculation.

Etiology

Although the disease is nonbacterial in origin, there have thus far been no successful attempts to isolate a virus. It can be transmitted to monkeys and man by inoculation of material obtained from lymph node aspiration. Because of the occurrence in some cases of positive complement-fixation tests to the antigen of Lygranum C. F., it is believed to be related to the lymphogranuloma-psittacosis group of diseases.[3]

The incubation period is said to run from a few days to six weeks. In case 4 of the present series it was 47 days.

Symptoms

The systemic manifestations are usually mild, consisting of fever varying from 99 F. to 102 F., rarely 104 F., chills, headache, malaise, and infrequently a skin rash. The regional lymphadenopathy usually involves the auxiliary or cervical nodes. Early there may be tenderness, redness, and swelling of considerable degree, which subside over a period of a few days. The node or nodes then persist as painless, firm enlargements for several weeks or months. The spleen is not enlarged, although in case 2 reported here this organ was palpable. Inspection of the skin almost always reveals the presence of the primary lesion, which appears as a slightly red, papular, tender mark which may persist for several weeks or months.

Diagnosis

By bearing cat scratch disease in mind, one usually has little difficulty in making the diagnosis, which is established by the presence of the following:

1. Regional lymphadenitis
2. Primary lesion or scratch mark
3. History of cat scratch in over 50 per cent of the cases
4. Positive intradermal test

The antigen for the intradermal test is made from pus aspirated from an infected lymph node. It is subjected to heat at 60 C. for two hours and then diluted 1:5 with normal saline. The test is performed by injecting 0.1 cc. of antigen intradermally and noting the reaction 24 to 48 hours later. When the reaction is positive, there develops a central papule surrounded by an area of erythema measuring from 5 to 25 mm. in diameter.[4,5,6]

To my knowledge the antigen for this test is not yet available commercially. All of the antigen

used in the cases reported herein was obtained from Drs. Worth B. Daniels and Frank G. MacMurray, Washington, D. C.[6] In return for the antigen it is requested that, should the opportunity present itself for lymph node aspiration, any prepared antigen from proved cases be shared with them, as the demand is high and the supply is low. A case history type of report is mailed separately and is expected to be completed in each instance, whether the reaction to the skin test is positive or negative.

LABORATORY OBSERVATIONS. — The leukocyte count is usually normal, but may reach 13,000. Sometimes the differential count reveals an increase in the eosinophils. The sedimentation rate is usually elevated. Early in the disease the serum globulin is elevated, returning to normal later in the disease, an observation also noted in cases of lymphogranuloma venereum. The heterophil antibody test is negative, as is usually the Frei test and the agglutination series. Lymph node biopsies usually reveal granulomas with microabscesses and intranuclear and intracytoplasmic inclusions.

DIFFERENTIAL DIAGNOSIS. — Cat scratch disease should be differentiated from tularemia, infectious mononucleosis, lymphatic tuberculosis, sporotrichosis, lymphogranuloma venereum, bacterial lymphadenitis, Hodgkin's disease, lymphosarcoma, and benign tumors.

Treatment

As with other diseases of viral etiology, nonspecific measures are generally employed. The use of tetracycline or oxytetracycline is believed to shorten the duration of the symptomatic period. The prognosis is almost always good.

Report of Cases

Case 1. — A three year old boy was treated for round worm infestation about two months prior to his present illness. The presenting complaints on May 29, 1954, consisted of fretfulness, sneezing bouts, redness and swelling about the eyes, and urticarial rash of the face, back, chest, and abdomen of about three days' duration. During the previous two weeks the mother had noticed a cycle of healing and reappearance of scratch marks on the dorsum of the left hand. These marks were inflicted by a six week old kitten, which the patient killed with a baseball bat after being scratched.

The physical examination revealed a temperature of 101.2 F. rectally, generalized urticaria, periocular edema, and generalized lympbadenopathy with a particularly enlarged solitary node the size of a pecan, tender to palpation and even noticeable on inspection of the left axilla. There were two scratch marks on the dorsum of the left hand, each about an inch in length. Four days later the intradermal test was performed. Two days thereafter the test site showed a central papule measuring 5 mm. in diameter and surrounded by a red zone 10 mm. in diameter. Although all systemic symptoms had subsided, a painless lymphadenopathy persisted. Fourteen days later, a stool examination was positive for Ascaris lumbricoides, and a cellophane perianal swab was positive for Enterobius vermicularis, for which appropriate treatment was instituted.

The last observation was on June 26, at which time the left axillary node was only slightly smaller and painless, and the scratch marks were still visible, although inflammatory redness had gone. This patient had concurrent urticaria, ascariasis and oxyuriasis, and cat scratch disease.

Case 2. — A boy, aged six years, was first seen by me on Jan. 7, 1956, because of a "big kernel" under the right arm for the previous seven days, fever of two days' duration, and no other symptoms. He recalled having been scratched by a cat in the recent past.

On physical examination, the temperature was 100.4 F. orally. A walnut-sized lymph node of the right axilla was plainly visible on inspection, even on posterior view, and generalized lymphadenopathy, a palpable spleen, and a slightly red papule of the right hand were noted. Urinalysis gave normal results, and the leukocyte count was 9,900 with a normal differential. Two days later, physical findings were unchanged. Tetracycline, 100 mg. every six hours for 20 doses, was administered. After four days, the primary lesion had subsided, although the axillary nodes remained unchanged. The intradermal test with cat scratch disease antigen produced a central indurated papule measuring 6 mm. in diameter, and surrounded by a zone of erythema 2.5 cm. in diameter. In another three days, the temperature had come down to 99.4 F., and the pain and malaise had subsided, but the physical findings persisted. The patient did not return for further follow-ups.

Case 3. — A boy, aged nine years, was first seen on Sept. 7, 1956, because of the presence of fever the previous night, and a painful swelling under the right arm for the previous 10 days. One week before tbe onset of axillary swelling, the child was scratched by a neighbor's cat.

Physical examination revealed the presence of redness, tenderness, heat, and swelling the size of a walnut in the right axilla. The epitrochlear lymph nodes were not palpable on the left, but tender and enlarged on the right. Immediately below the elbow a small red papule was seen. Within three days the patient became afebrile, and the primary lesion was no longer red, but the lymphadenopathy persisted. The hemoglobin estimation and tbe red blood cell, the white blood cell and the differential counts were normal, as was the result of urinalysis. He was given tetracycline, 100 mg. every six hours for 25 doses. Five days later, the sedimentation rate was 18 mm/hour, and agglutinations were reported negative for typhoid "O", brucellosis, and tularemia. The heterophil antibody and the serologic test for syphilis were negative. Two days later, the intradermal test showed a central indurated papule measuring 5 mm. in diameter, which was interpreted as being positive.

On Jan. 8, 1957, the right axillary lymph node was enlarged to the size of an almond. The patient had been asymptomatic during the intervening time and had continued to feel well. He was seen again about six months later, when enlargement of the right axillary lymph node was no longer detectable.

Case 4.—A girl, aged four years, was first seen on Oct. 27, 1956, because of a painless swelling in the region of the left jaw, which was first noticed by the mother a week before. There was no history of exposure to mumps. The mother stated that the child had been scratched by a neighbor's cat on September 3.

On physical examination, the temperature was not elevated, but there was a large, firm, nontender swelling in the region of the left parotid gland. Two inches below the swelling was a small reddish papule or scratch mark. On October 29, the administration of tetracycline, 125 mg. every six hours, was begun. On this date the sedimentation rate was 15 mm. in one hour, the urine showed a trace of sugar, the white blood cell count was 8,500, and the differential count revealed 1 per cent juvenile, 3 per

cent stab and 43 per cent segmented forms, 50 per cent lymphocytes, and 3 per cent eosinophils. Agglutinations for typhoid "O" and brucellosis were negative, as were the heterophil antibody and the serologic test for syphilis. Urinalysis on November 5 gave normal results. The intradermal test showed an indurated, red papule 2 mm. in diameter, surrounded by a zone of erythema measuring 15 by 17 mm.

By November 16, the lymphadenopathy had almost disappeared, and the scratch mark was still plainly visible, although signs of inflammation had gone. The patient was not seen again for follow-up observation.

Summary

Four cases of cat scratch disease are reported. The etiology, symptoms, diagnosis and treatment of this disease are discussed.

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Use of Gamma Globulin in Treatment Of Lymphomas

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The use of human gamma globulin in the therapy of the lymphomas was thought of as a possibility for the following reasons:

1. The easy transmissibility of leukemia in certain lower animals, namely, rats and chickens, and the apparent impossibility of transmission in humans.[1] These findings were interpreted as indicative of the possibility that most humans present an inherent immunity. It was thought that this immunity might conceivably be due to a previous infection. There is some evidence to show that leukemia may be caused by a virus infection,[2] and since most adults have had the various virus infections, it was thought that this immunity might be on a previous infection basis.

2. The difference in life expectancy in adults and children with leukemia. Children usually have the acute form and die within a year while adults usually have a chronic form which reduces the life expectancy roughly only 20 per cent. It was believed that this difference in duration could be explained on the possible basis that adults may have a partial immunity, due to a previous childhood infection.

3. Since children have been born with leukemia, it was thought that possibly this group represents a small percentage of patients whose mothers had acute subclinical leukemia shortly before the natal period and that the leukemic infants represent those who had a basic inability to develop an immunity against this given stimulus.[3]

4. Additional evidence in favor of the virus idea is the frequent acute febrile onset of acute leukemia.

5. Since most of us, as adults, have had, as mentioned before, most of the virus infections, and since acute leukemia is not the most common disease in the world, it was believed that these children with acute leukemia could represent the few who did not have an ability to develop an immunity against a given leukemia stimulus, as opposed to most of us who possibly could have had acute leukemia in a subclinical undiagnosed form as an acute febrile illness of childhood.

6. Recent transplantation experiments in tumors apparently show that persons with advanced malignant disease can become a host to a foreign tumor implanted under the skin while those without an advanced malignant condition are unable to become a host. It was thought also that this possibly could represent an immune reaction in those who did not have cancer.[4]

Report of Cases

Case 1.—On May 14, 1957, with the kind assistance of Dr. Louis Barreras, Hematologist at the Infants Hospital, University of Havana, Havana, Cuba, a seven month old male infant with acute lymphoblastic leukemia, who weighed 15 pounds, was given 50 cc. (8 Gm.) of concentrated gamma globulin diluted in normal saline to a 1.5 per cent solution. This child had had no previous therapy. For the past three to four weeks, he had been febrile and somewhat listless and had lost his appetite; for a day or two before admission to the hospital, he had been vomiting everything taken by mouth. His weight previous to his illness was not known. The parents, however, thought that he had lost weight. On the day

before the administration of the gamma globulin, the hemoglobin estimation was 70 per cent, the red blood cell count was 3.9 million, and the differential count was polymorphonuclears 10 per cent, stab forms 2 per cent, lymphocytes 30 per cent, monocytes 2 per cent and lymphoblasts 56 per cent.

The first 150 cc. of the diluted gamma globulin solution was given intravenously over a period of two hours and was tolerated well at first. Pronounced dypsnea, some cyanosis, course rales over both lungs and tachycardia then developed, and the temperature was 39.2 C. (102.6 F.) axillary. The gamma globulin was immediately discontinued, and the patient was given 0.1 cc. of epinephrine subcutaneously. The respiratory symptoms gradually subsided and the cyanosis improved, but the temperature remained elevated and fluctuated up to 39.2 C. (102.6 F.) for 24 hours. The following day, the red blood cell count was 2.2 million, the white blood cell count was 45,000, the hemoglobin estimation was 40 per cent, and the differential count was polymorphonuclears 20 per cent, stab forms 1 per cent, lymphocytes 46 per cent, monocytes 2 per cent and lymphoblasts 31 per cent.

Clinically, it was observed that the spleen, which prior to therapy was approximately 6 cm. below the left costal margin, was now roughly 3 cm. below. The remaining 350 cc. of gamma globulin solution was given subcutaneously during the next 24 hours without appreciable untoward reaction. On the following day, which was two days after the initiation of the therapy, the red blood cells numbered 2.46 million, the white blood cell count was 5,000, the hemoglobin estimation was 35 per cent, and the differential count was polymorphonuclears 5 per cent, stab forms 2 per cent and lymphoblasts 15 per cent. Concomitant with this improvement in the blood picture, the patient also showed considerable clinical improvement. He took his feedings with relish, the spleen was appreciably smaller, and he looked better.

Gamma globulin was given weekly in 5 cc. doses intramuscularly, and 10 days after the initial therapy, the differential blood count was normal, and there was a spontaneous rise in the hemoglobin to 55 per cent. Also, physical examination was normal, and it was doubtful that the spleen could be palpated.

This remission was maintained for approximately one month, during which time the peripheral blood and bone marrow returned to normal. At the end of this period lymphoblasts were again present in the peripheral blood, and the spleen was enlarged. It was concluded that the infant was having a typical exacerbation of acute leukemia. Gamma globulin was discontinued, and therapy with the corticosteroids was begun.

Case 2.—A 10 year old boy with lymphosarcoma was first seen on May 13, 1957, complaining of pain in the back following a minor injury three months previously. At this time pains radiated into his legs, particularly at night. He was known to have weighed 90 pounds five months before and on May 13 he weighed 76 pounds. Radiographs showed destruction of the first sacral vertebra, and a barium enema revealed displacement of the rectum and sigmoid anteriorly.

A diagnosis of a tumor, probably lymphosarcoma, was made, and an exploratory abdominal operation was performed on June 1. A large mass was found anterior to the sacrum which had encompassed a loop of small intestine. The entire abdomen was filled with what apparently were metastatic lesions. The mass encircling the intestine was resected along with the piece of intestine, and pathologic diagnosis was lymphosarcoma. There were no peripheral blood changes although the bone marrow was interpreted as giving evidence of lymphosarcoma, but not the type that can convert to acute leukemia.

On the first postoperative day, the patient was given 410 cc. of concentrated gamma globulin diluted in 1,600 cc. of normal saline. This was given slowly subcutaneously over a period of 12 hours. He had essentially no reaction except for a slight erythema of one leg, which subsided two days later. Minor clinical improvement seemed apparent for a day or two after the administration of the gamma globulin, but the child gradually became worse and died on June 28.

Case 3.—A seven year old boy with aleukemic leukemia, who weighed 49 pounds, was given 200 cc. of concentrated gamma globulin diluted in normal saline to a 3 per cent solution. The total white blood cell count, after the administration of the gamma globulin solution, rose from 2,500 on the day of admission to 5,000 two days later, but failed to improve thereafter, and it was concluded that the gamma globulin did not benefit him appreciably.

Comment

In retrospect, the improvement of the infant in case 1, which looked extremely encouraging for the first month, was probably not due to the gamma globulin but rather to the moderately severe reaction to this material intravenously.

The most logical conclusion to draw would be that this reaction liberated a good deal of the corticosteroids from the adrenal gland, producing a temporary remission. The rapid fall in the hemoglobin and red blood cells along with the concomitant reduction in the white blood cells and lymphoblasts is also noteworthy. I think this definitely speaks for a toxic depression of the red cell—producing marrow rather than a mechanical reduction.

Summary

Large doses of human gamma globulin were given to three patients with lymphomatous disease.

Except for a remission of approximately one month in the first patient, no beneficial effects from gamma globulin were noted.

The beneficial effects in the first case probably were not due to the gamma globulin per se but rather to the reaction the baby had following the intravenous administration of this material.

It is safe to give very large doses of human gamma globulin subcutaneously.*

*The gamma globulin was supplied through the courtesy of the American National Red Cross Blood Program and Pitman-Moore Laboratories, Indianapolis, Ind.

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ABSTRACTS

Physiological Aspects of Protein Depletion and Restoration in Surgical Patients. By Donald W. Smith, M.D. Am. Surgeon 23:409-419 (May) 1957.

This comprehensive study with an extensive bibliography stresses the importance of the early recognition of protein depletion or deficit and an understanding of the mechanisms involved in its development since they are essential for proper management of this serious complication of disease or injury. The various reasons for inadequate intake and the methods and routes of protein loss are discussed, and their early correction is emphasized. While the extra renal losses by transudates, emesis, diarrhea, and intestinal fistulas and those of repeated hemorrhage are well known, the magnitude of urinary nitrogen excretion due to "stress" of disease, major burns, fractures and other trauma and of surgical procedures and even prolonged immobilization and bed rest is not generally appreciated. When this loss is imposed upon an already malnourished patient, its correction may be almost impossible and the continuing negative nitrogen balance will lead to body protein depletion with all of its well known complications such as impaired wound healing, edema and ulceration of respiratory and intestinal mucosa, ileus, infections and oliguria. Chronic shock and its correction also are discussed. In this nutritional problem the diminished hemoglobin and serum protein result in a diminished blood volume.

Methods of reproteinization of the depleted patient are discussed with particular emphasis on the time factors in protein metabolism and synthesis. It appears that frequent, almost hourly, or continuous around the clock feeding for maximal utilization of protein is acceptable and most effective. The problems of intolerance and rejection of forced nutrition are acknowledged and create a challenge to the thoughtful surgeon.

Isolated ("Primary") Chylopericardium Due to Anomalous Communications with the Thoracic Duct, of Unknown Causation. By William M. Madison, Jr., M.D. and Bruce Logue, M.D. Am. J. Med. 22:825-830 (May) 1957.

The second case of a rare entity, isolated or primary chylopericardium, is here reported. By the use of lipophilic dyes an anatomic communication between the thoracic duct and the pericardial cavity was demonstrated, but at operation no direct communication was identified. The etiology of the chylous pericardial effusion in this case is unknown. Ligation and excision of both major lymphatic channels and all collaterals low in the thorax together with the establishment of a pericardial window for drainage resulted in an apparent cure.

Enzymatic Degradation of Certain Constituents of Cervical Mucus. A Pilot Study in Mice of the Congenital Effect of Intravaginal Streptokinase-Streptodornase. By Murray M. Streitfeld, Ph.D., Frank H. J. Figge, Ph.D., and Joseph W. Scott, M.D. Fertil. & Steril. 8:455-464 (Sept.-Oct.) 1957.

A pilot study is reported on the investigation of enzymatic preparations that may act to break down certain constituents of cervical mucus and thereby permit fertilization in cases of sterility due to highly viscous mucus acting as a barrier to the passage of spermatozoa. Streptococcal enzymatic concentrates of streptokinase-streptodornase were studied in three generations of mice, of strains LCSa, C57, and A, to provide information as to whether intravaginal instillation of the preparations immediately prior to copulation would affect the offspring issuing from this mating.

The results are believed to indicate that intravaginal treatment of female mice with streptokinise-streptodornase preparations definitely mediated adverse congenital effects. The findings are discussed from the standpoint of attempted identification of a toxic congenital factor in streptokinase-streptodornase preparations. The investigation emphasizes the need for study of the congenital effects that may be produced by contact with spermatozoa of enzymes elaborated by beta-hemolytic streptococci in infection of the female or male genital tract or accessory glands.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

San Francisco

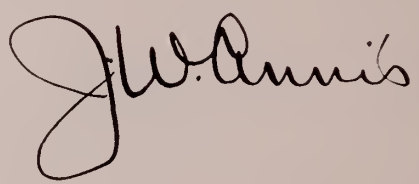
The Florida sun shone brightly over the cool grey city of San Francisco during the annual June meeting of the American Medical Association. No fog—no rain—no grey skies, but instead beautiful bright sunshine illuminating the election of Louis M. Orr of Orlando as President-Elect of the American Medical Association.

Never before has this highest honor in medicine been bestowed upon a Florida physician and only rarely has the position visited the Deep South. The unanimous and unopposed selection of Dr. Orr by the House of Delegates of the American Medical Association was certainly a great source of pleasure, pride, and reflected glory to each Florida physician. All of us are not only happy for Louis, but are deeply indebted to him for bringing this honor to our state. Mr. President-Elect—our congratulations and our solid support during your administration!

In addition, it was also a matter of considerable pride to see our delegate, Dr. Reuben B. Chrisman Jr., reseated as a member of the Council on Medical Service by an overwhelming vote. Again, a real and sincere tribute to a colleague of whom we are rightfully proud.

And finally, the Board of Trustees' selection of Miami Beach as the meeting place for the annual meeting of the American Medical Association in 1960—and its subsequent ratification by the House of Delegates—were parting words of happiness and success to all of us from Florida.

Indeed it was a wonderful convention in every way. The San Franciscans and all the Californians were perfect and genial hosts, and American Medicine was most kind to the physicians of Florida. We are most humbly appreciative.



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Dr. Louis McDonald Orr, President-Elect Of the American Medical Association

In San Francisco on June 26, 1958, at the 107th Annual Meeting of the American Medical Association, the House of Delegates unanimously elected Dr. Louis McDonald Orr, a distinguished urologist of Orlando, to be President-Elect. He will accede to the office of President at the Atlantic City convention in June 1959.

A Georgian and a descendant of a Revolutionary War patriot, Dr. Orr was born on Sept. 27, 1899, in Cumming, Forsyth County, Georgia, while his parents were on a six week wagon journey to visit his father's only brother. His earliest years were spent in Greensboro, Ga., and Dothan, Ala. When he was six, the family moved to Brunswick, Ga., where he attended elementary school and high school at Glynn Academy. He also received his academic and professional training in his native state. In 1921 he was graduated from Emory University with the degree of Bachelor of Science and in 1924 was among the top five in his class when he was awarded the degree of Doctor of Medicine by the Emory University School of Medicine. After completing an internship at Peter Bent Brigham Hospital in Boston, he served as a resident in urology and general surgery in the old Lakeside Hospital in Cleveland. The young doctor then decided to engage in the private practice of his profession in Orlando, where his brother Clifton was in business. He opened his office there in February 1927.

From the outset of his career, Dr. Orr has been active in the organizational side of medicine, first on the state and then on the national level. His first office in the Florida Medical Association was that of Associate Editor of The Journal, a post he has held continuously since 1933. Through the years he has served as Councilor for his district and on various regular and special committees. For the last 10 years he has been a member of the Association's House of Delegates, serving for seven years as chairman of the Credentials Committee. In 1954-1955 he was a member of the Board of Governors.

Since 1948 Dr. Orr has served the Florida Medical Association with distinction as one of its representatives in the House of Delegates of the

American Medical Association. The national body was as quick to recognize his sterling qualities and leadership ability as was the state society, and he was soon filling important posts. He has served as chairman of the Federal Medical Services Committee, as an ex-officio member of the Council on Constitution and By-Laws and as a member of the Council on Medical Service. He was elected vice-speaker of the House of Delegates in 1955 and continued to serve in that capacity until he became President-Elect.

A medical writer of note, Dr. Orr has made more than 50 contributions to scientific literature. He has been one of the moving spirits in the Florida Medical Committee for Better Government. Affiliated with numerous surgical and urologic societies, he has served as president of the Southeastern Section of the American Urological Association.

During World War II, Dr. Orr was a colonel in the Army Medical Corps. He served from 1943 to 1945 as commanding officer of the 15th Hospital Center in the European Theatre of Operations and after the war received many honors both in the United States and in Great Britain.

While a surgical house officer in Peter Bent Brigham Hospital in Boston, Dr. Orr met Miss Dorothy Brown. They were married on Dec. 16, 1927. Their son, Louis McDonald Orr Jr., 24 years of age, is in Atlanta studying medicine at Emory University School of Medicine, and their daughter, Doris Brown Orr, aged 18, was graduated from Mount Vernon Seminary in Washington, D. C., in June of this year.

In Orlando, Dr. and Mrs. Orr have been prominently identified through the years with many civic and social activities, among them the Central Florida Civic Music Association, which Dr. Orr served as president from 1939 to 1952. In 1938 they made possible through financial gifts the establishment of the fourth blood bank in America at Orange Memorial Hospital in Orlando. For 14 years Dr. Orr also served as a trustee of Rollins College in nearby Winter Park. He is a devout churchman, a member of the Episcopal Cathedral Church of St. Luke in Orlando.

Dr. Orr's rich medical background, his broad experience and his dynamic personality assure the American Medical Association of able leadership from a wisely chosen President. He will grace the office he assumes in 1959.

Dr. Orr's Election A First for Florida Medicine

For the first time in the 84 year history of the Florida Medical Association a president of the American Medical Association has been chosen from its ranks. The election of Dr. Louis McDonald Orr of Orlando to the office of President-Elect at the recent San Francisco meeting of that body conferred this distinction on his state society. Dr. Orr is now eligible to join, when he takes office in June 1959, a coterie of 22 eminent Southerners who have held the highest office in American Medicine. In more than a century of existence, the American Medical Association has had one president from Louisiana, one from South Carolina, two from Alabama, two from Georgia, three from Virginia, six from Tennessee and seven from Kentucky. Now Florida is to be added to the list.

Dr. Homer L. Pearson Jr. of Miami, who for several years has had the signal honor of heading the Judicial Council of the American Medical Association, was accorded the privilege of placing Dr. Orr's name in nomination. His nominating speech was brief and to the point:

"It is impossible for any doctor to attain the stature necessary to be considered president-elect material without being fairly well known to the members of this House. I therefore would not burden you with a long biography of your vice-

Opposite

Following his election as President-Elect, Dr. Orr is congratulated by Dr. F. J. L. Blasingame, Executive Vice President, American Medical Association (1); Dr. Samuel M. Day of Jacksonville (left), Secretary-Treasurer, Florida Medical Association, and Dr. Jere W. Annis of Lakeland, President, Florida Medical Association (2); From left, Dr. Reuben B. Chrisman Jr. of Coral Gables, Florida Medical Association Delegate to the American Medical Association, Dr. Homer L. Pearson Jr. of Miami, Chairman of the Judicial Council American Medical Association, and Dr. Francis T. Holland of Tallahassee, Florida Medical Association Delegate to the American Medical Association (3). Dr. and Mrs. Orr (4). Dr. Orr performs his duties as Vice Speaker of the House of Delegates, American Medical Association (5). Dr. W. Linwood Ball of Richmond, Va., Vice President of the American Medical Association, extends good wishes to Dr. Orr (6).




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speaker, but in the names of the doctors of Florida in general and for Francis Holland, Reuben Chrisman and myself in particular, I am privileged to nominate for President-Elect of the American Medical Association your most capable and genial vice-speaker, Louis McDonald Orr."

The nomination was seconded by numerous states, among them North Carolina, West Virginia, Connecticut, Illinois, Georgia, Wisconsin, Texas, Alabama, Nebraska, Tennessee, Pennsylvania, Michigan and Ohio. There were no other nominations, and Dr. Orr was unanimously elected. His acceptance speech was likewise brief:

"Mr. Speaker, Members of the House of Delegates: I do not have the words available to express to you my deep appreciation for the honor you have bestowed upon me. I can assure you that I will serve you to the very best of my ability and with all the determination and ability at my command."

His Florida colleagues know that Dr. Orr's best will be freely and fully given and will be more than enough to meet the exacting demands of his high office. Florida Medicine is proud to be represented by a physician of his stature when it takes its place next June as the eighth Southern state to furnish to the American Medical Association a president.

When Dr. Orr yields the gavel to his successor in 1960, he will do so on Florida soil. The 1960 meeting of the American Medical Association will be held in Miami Beach.

Are We Neglecting Art as We Emphasize Science In the Practice of Medicine?

A recent poll of a representative segment of the population shows that while a large majority hold their own personal physicians in high esteem, many have a lower regard for physicians as a group. This finding appears to indicate that although unfavorable publicity does not seem to affect greatly the personal relationship between patient and physician, it does appear to harm the medical profession as a whole.

The incident of the physician assisting in a rescue mission at a well a year or more ago is a case in point. When the physician-anesthesiologist rendered a large fee to the family of the little victim, he struck a blow with an impact which resounded nationwide. Repeated explanations and attempts to justify his position did not seem to soften the blow materially. Thousands of unselfish, public-spirited reactions on the part of many physicians could not cancel or overbalance that one apparent indiscretion.

Placing a fair and just price on one's professional services frequently requires judgment and wisdom. One of the best-loved members of the Florida Medical Association, a past president and elder statesman residing in Northwest Florida, some years ago amusingly revealed to a group of friends how he met this problem. On the last afternoon in the month, or perhaps not until the end of the quarter, he secluded himself with his records in a remote office of an old warehouse on his property to ponder his problems. As he sipped spiritus frumenti reserved for that occasion, he gradually developed courage enough to put a price on services he had rendered friends and patients. A surgeon friend, who had had less difficulty in pricing his professional services, told how he had on one occasion charged and collected what he felt was a just fee from a wealthy patient. He had rendered a statement for $1,000, and the patient had written to ask for an itemized account. The next statement read:

To Professional Services:	
Removal of Tumor	$ 50.00
Knowing How	950.00
Total	$1,000.00

The surgeon did not find it necessary to emphasize the time and expert care that had been devoted to proper preoperative preparation and postoperative care, but he had a sense of balance and a sense of humor appropriate to the occasion.

Time is the essence; time is the commodity that is so necessary in properly handling the patient, and time is the essential of which few professional men ever seem to have enough. The internist, the diagnostician, needs time for careful history taking, and the patient frequently needs to talk, but despite it having been repeatedly shown that good history taking is of great importance in the over-all study of a patient, that

part of the study is frequently short-circuited because the physician feels that he does not have time to devote to it. It is much easier to order laboratory, x-ray and clinical studies which a technician can perform, and the patient frequently is impressed by elaborate equipment and scientific tests. Some patients put much emphasis on a yearly trip to a medical center for "thorough" studies. One such patient recently returned with many negative studies and a reassuring report, who apparently through some mistake was questioned and interviewed only very briefly. A brief conference with the patient by a local physician revealed slurred speech and improper cerebration, while a neurologic examination showed abnormal reflexes. In short, a correct diagnosis of "slight cerebral vascular accident" was made by a history and physical examination alone in the face of recently reported negative clinical studies.

Repeatedly, patients go from clinic to clinic searching for a diagnosis, spending a great deal of money on repeated elaborate clinical studies ordered by young house officers in their training period, when the patient actually needs some kind, thoughtful, mature physician to sit down with him and point out that his difficulty is largely functional in nature and that if he hopes to get well, it will be necessary for him to make an entirely different approach to his problem.

In comparatively recent years more and more light has been shed on the psychosomatic nature of many illnesses. Physicians who have been trained, and correctly so, to search for structural disease are amazed to find that the majority of patients who present themselves for study are suffering from illnesses which are largely psychosomatic in origin. Patience, kindness and wisdom on the part of the physician are essential to the adequate handling of all patients, but particularly those who have functional illnesses. No matter how brilliant the physician, if he is not kind and if he does not establish a rapport between the patient and himself, it will be difficult for him to obtain good results. The patient who loves and trusts his physician will defend him in error, whereas a patient, even though treated brilliantly and cured of a difficult illness, is apt to find fault and show lack of appreciation when there has been brusqueness, unpleasantness and lack of rapport. The high cost of premiums for malpractice insurance is mute evidence to the increasing inadequate handling of the ill.

There are still those who would bring a third person into the patient-physician relationship—who would establish compulsory insurance and eventually bring about socialized medicine. These politicians who know little about the practice of medicine appeal particularly to patients who are dissatisfied and have been handled less than well by their physicians. It is they who will listen more avidly to the something-for-nothing promises. One look at medical practice in England shows that a good diagnostic study is almost a thing of the past. Physicians' offices are overflowing with the chronic complainers who never seem to feel very well and who are willing to wait for the doctor and a free handout of medicine for their minor complaints. One look at this picture should spur us to establish better rapport with our patients.

No matter how brilliantly we have progressed in the United States with scientific treatment of patients, we will do well to remember that the effective physician does not forget to practice the art as well as the science of medicine.

Orange County Medical Society Fiftieth Anniversary Celebration

More than 325 members and guests of the Orange County Medical Society gathered at the Country Club of Orlando on the evening of May 27, 1958, to celebrate the fiftieth anniversary of the founding of the society. During the cocktail hour and at the dinner many happy reminiscences were exchanged as the members and their friends looked back across the society's half century of gratifying progress. The names of the founding members, all now deceased, were recalled by Mr. DeWitt Miller, who had known many of them, and their achievements were reviewed as the society's story was unfolded. Past presidents were called upon to rise and be appropriately greeted. In commemoration of this historic event, Mayor Robert S. Carr proclaimed the week of May 25 as Orange County Medical Society Week, and members of the society wore red carnations to mark its observance.

This important county society of 227 members had its beginning in 1908 when 10 physicians from Orlando and Sanford met in Orlando at the home of Dr. J. S. McEwan. They were Drs. Jerome Bruce, N. Devere Howard and W. S. King of Sanford, and Drs. C. D. Christ, Washington Kilmer, Sylvan McElroy, J. S. McEwan, W. C. Person, George Porter and J. S. Rush of Orlando. Dr. Rush was the first president and Dr. McEwan the first secretary.

Florida's distinguished author-physician, Dr. Frank G. Slaughter of Jacksonville, was the guest speaker on this auspicious anniversary occasion. "The Physician's Heritage" was the subject of his address. He traced the development of medicine from the dawn of history down through the ages to the present brilliant era, citing medicine's impact on other fields of knowledge and endeavor across the centuries. "No other learned profession goes so far back into the very roots of history," he observed as he reminded physicians that they should be proud of their heritage from the past and the obligation it places upon them for future leadership.

Optimistic about the future, he continued. "When we think that a single pound of heavy water gives the same energy as half a million pounds of coal, yet costs only $28, we begin to get some insight into the vast changes which the discovery of some method for harnessing the tremendous energy of the hydrogen atom will bring to the world. It can truly be said that mankind stands almost on the threshold of a millenium in which there need not be poverty and lack of food or the necessities of life for any person upon the globe. Already the tremendous advances in preventing and treating disease, particularly with antibiotic drugs and the efficiency of modern surgery aided by various scientific advances in that field, have changed the face of medical practice. More and more we are dealing with an older population in which the economic problems concerned with the provision of medical care will almost certainly increase considerably as the years go by.

"These things mean inevitably that the physician can no longer occupy an isolated place in the world and limit himself entirely to the day to day practice of his profession. Whether we wish it or like it, we as a profession are certainly going to have to play a much more integral role, not only in the care of diseased mankind but also in the field of public health, geriatrics, and medical sociology and economics. It behooves us, therefore, as we move from fifty years of what might be called the Golden Age of medicine into an era whose problems are inevitably going to be considerably different from those we have faced in the past, to remember the obligation of our long heritage and to assume the positions of leadership which are our right, our duty, and which will certainly devolve upon us.

"In paying tribute, therefore, tonight to our ancient heritage, we also cannot escape facing the obligations which that heritage places upon us. Even as Stone Age men looked to their shaman or medicine man for guidance, so the world today will expect guidance and leadership from the medical profession. This is the heritage we must assume in the future, certainly as important and as demanding a one as the heritage which we acquire from the past when we accept the title of doctor of medicine."

The Orange County Medical Society is to be congratulated on its 50 years of service to the community—a fitting prologue to a second half century of medicine rendered in the best tradition of the profession.

Governor's Citizens Medical Committee On Health

By decree of Governor LeRoy Collins, the State of Florida now has a functioning Citizens Medical Committee on Health. Acting favorably upon the recommendation of the Florida Medical Association that such a committee be established, Governor Collins issued the following statement and executive order on April 4, 1958:

April 4, 1958

STATEMENT BY GOVERNOR LEROY COLLINS

I was greatly encouraged by the study of the citizens committee which fostered the development of the hospital service for the indigent program. This program has gained nationwide attention and is serving as a model for legislation in several other states.

At the same time, the program revealed that further study was needed in other phases of indigent medical care. Our goal must be to provide the people of the State of Florida with the finest possible health program and services.

I have therefore created a Citizens Medical Committee on Health to make further studies and I feel confident that the work of this committee will be a significant step toward our goal.

STATE OF FLORIDA
EXECUTIVE DEPARTMENT
TALLAHASSEE

WHEREAS, in the field of public health, the State of Florida should provide its people with

the finest possible health planning and services, and

WHEREAS, the citizens committee which recommended the Florida Hospital Service for the Indigent program recognizes that further study is needed in other phases of indigent medical care, particularly in the area of out-patient services and care of the chronically ill, and

WHEREAS, the Committee on Legislation and Public Policy of the Florida Medical Association, with the approval of the Board of Governors of the Association, has requested this further study be undertaken, and

WHEREAS, it is important that there be established in Florida a committee of citizens to study and give direction to the activities of the State in these phases of public health,

NOW, THEREFORE, I, LeRoy Collins, by virtue of the authority vested in me as Governor of the State of Florida, do hereby:

1. Create the Citizens Medical Committee on Health which shall meet whenever necessary to study and make recommendations in the areas of:
   a. Care of chronically ill and aged indigents
   b. Out-patient care of indigents
   c. Coordination and maximum utilization of state agencies rendering health services
   d. Role of volunteer health agencies operating in Florida
   e. Maximum utilization of personnal trained in the health field
   f. Additional areas of study deemed advisable by the Committee

2. The Committee shall consist of the following members who shall serve at the pleasure of the Governor and without compensation:

Dr. Edward R. Annis, 2300 Biscayne Boulevard, Miami
Dr. Edson J. Andrews, 205 E. College, Tallahassee
Dr. Leffie M. Carlton, Jr., Citizens Building, Tampa
Dr. Edward W. Cullipher, 2957 S. W. 22nd Street, Miami
Dr. Thomas W. Dorr, 512 Citizens Building, Tampa
Dr. Samuel Gertman, 1431 N. Bayshore Boulevard, Miami
Dr. H. Phillip Hampton, Citizens Building, Tampa
Dr. George T. Harrell, Jr., Dean, College of Medicine, University of Florida, Gainesville
Dr. S. Carnes Harvard, P. O. Box 313, Brooksville
Hon. W. C. Herrell, Representative, Dade County, 173 Narvarre Drive, Miami Springs
Dr. Francis T. Holland, 1307 Miccosukee Road, Tallahassee
Dr. Edward Jelks, 2244 St. Johns Avenue, Jacksonville
Dr. John D. Milton, 701 Huntington Building, Miami
Mr. W. Harold Parham, P. O. Box 2411, Jacksonville 3
Dr. Homer L. Pearson, Jr., 901 N. W. 17th Street, Miami
Hon. Verle A. Pope, State Senator, 31st District, P. O. Box 519, St. Augustine
Dr. W. D. Rogers, Director, State Mental Institutions, Chattahoochee
Dr. Richard G. Skinner, Jr., 3241 Beach Boulevard, Jacksonville
Dr. Wilson T. Sowder, State Health Officer, P. O. Box 210, Jacksonville 1
Dr. Robert L. Tolle, 1504 Kuhl Avenue, Orlando
Dr. William M. C. Wilhoit, Medical Center Clinic Building, Pensacola
Mr. Steve F. McCrimmon, Administrative Director, Miami Baptist Hospital, Miami

3. Dr. Edward R. Annis is designated as Chairman of the Committee and shall call the members together at a time and place to be selected by him. At the organization meeting, the Committee shall select those additional officers it considers necessary and shall prepare those by-laws it deems advisable to meet its responsibilities under this Executive Order.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 4th day of April, A. D. 1958

(Signed) LeRoy Collins

GOVERNOR

ATTEST:
(Signed) R. A. Gray

SECRETARY OF STATE

ORGANIZATION. — The organizational meeting of the committee was held on May 10, 1958, at the Americana Hotel in Bal Harbour, North Miami Beach, with the chairman, Dr. Edward R. Annis of Miami, presiding. Dr. Annis requested Dr. H. Phillip Hampton of Tampa to serve as vice-chairman of the committee and to present the scope of the study to be undertaken.

In outlining the nature of the program, Dr. Hampton explained that the committee's purpose was to study and make recommendations with regard to the care of chronically ill and aged indigents, the outpatient care of indigents, the coordination and maximum utilization of state agencies rendering health services, the role of volunteer health agencies operating in Florida, the maximum utilization of personnel trained in the health field, and any additional areas of study deemed advisable by the committee.

Dr. Hampton also made specific reference to the origin, development and current activities of the Hospital Service for the Indigent Program, mentioned by Governor Collins in his statement, and pointed out that the House of Delegates of the Florida Medical Association, at the annual meeting in April 1954, recommended to the Governor that a citizens committee be appointed. It was through the efforts of this committee and Governor Collins that this program was implemented, with results that have been most gratifying.

Four important sub-committees were appointed by Dr. Annis and their special assignments announced:

SUB-COMMITTEE NO. 1: CARE OF CHRONICALLY ILL AND AGED INDIGENTS; OUTPATIENT CARE OF INDIGENTS.—Dr. Hampton, chairman, Drs. Samuel Gertman, George T. Harrell Jr., S. Carnes Harvard, W. D. Rogers and Wilson T. Sowder and Mr. Steve F. McCrimmon comprise this committee. It will study Florida's changing population; present medical care facilities for chronically ill indigents, including hospital, outpatient, nursing home and foster home facilities; community services for the aged and chronically ill, such as the Visiting Nurses Association; cancer, cardiac and geriatrics clinics and case finding; insurance for chronic illnesses of the aged; and other resources currently available. There will also be consideration of distinctive health and medical problems of the aged and health promotion in the fields of education and rehabilitation.

Studies in the State Board of Health, Jacksonville.—A number of the study projects outlined will be carried out within the Florida State Board of Health. The Bureau of Vital Statistics will summarize available statistical data indicating population trends and will direct attention to features of major importance in mortality and morbidity. The Bureau of Special Health Services will summarize the basic data on cases handled through the state's program for the hospitalization of the medically indigent; age, sex, race, welfare status, duration of stay and cost will be tabulated according to the county of residence and the hospital providing care and by diagnosis. The Nursing Home Division of this Bureau will gather information concerning the number of nursing homes in Florida, the ownership, the nature of nursing services provided and bed capacities. The Division of Public Health Nursing will survey ancillary home services, giving particular attention to the Visiting Nurses Association and other organized home nursing care programs with regard to the present organization of services, the number of nurses engaged, the charges for service, the total cost of services and the total number of visits and of patients served as well as the criteria for admission to service and the distribution of cases by diagnosis in so far as possible.

A one day census of hospitals and nursing homes is planned by the Bureau of Special Health Services and the Bureau of Vital Statistics with the cooperation of the Florida Hospital Association and of the Nursing Home Operators. The data sought for tabulation include a small number of important items which the nurse, business office or operator of a nursing home can provide. The hospital census is planned at a winter peak, at a summer peak and in an off season.

The last of the studies to be undertaken within the State Board of Health will also be carried out by the Bureau of Special Health Services and will concern the computed cost of medical services to indigents in hospitals. The budgetary value of medical services provided free will be computed by the Blue Shield and possibly another fee schedule for a representative sample of cases. The findings will then be used to compute the total costs of these services according to the specified fee schedule.

Studies in Survey Area.—Studies in a given survey area by a carefully chosen survey team constitute another project of Sub-Committee No. 1. The survey area will include four counties,

Hillsborough, Pinellas, Pasco and Hernando, and the survey team will be led by the Assistant Health Officers of Hillsborough and Pinellas counties. The consultative assistance of Dr. Edward Press, Field Director of the American Health Association, and others will be available.

The survey team will seek to determine the Visiting Nurses Association; cancer, Cardiac and extent to which the present program for hospitalization fails to meet present needs. The nature of local supplementary programs for the hospitalization of indigents will be ascertained in so far as possible. The chief objective will be to measure the extent of lack of indicated hospitalization of the indigent and the various factors accounting for this deficiency. Data relating to the interrelationship of convalescent and nursing home care to the hospital care for the acutely ill will be obtained. In addition, the extent of all outpatient, emergency and other clinic services will be determined for the two sample urban and the two sample rural counties comprising the survey area. Data will be assembled relating to the total number of patients and of visits, the charges per visit, the cost of services, the nature of illnesses and, if obtainable, the age, sex, race and welfare status of those served.

The nursing home population will be studied by the survey team. On each patient in a nursing home more detailed data will be sought concerning the reason for admission, the length of stay, the medical, nursing and mental status, and the cost and source of payment for the nursing home care. If available, an annual summary of all admissions and discharges for each home will be collected. Through various sources the role of boarding homes and private homes (caring for nonfamily members) in providing services similar to those in nursing homes will likewise be examined.

Using appropriate home interview technics, the survey team hopes to study distinctive health and medical problems of the aged by examining these problems in a representative sample of families with one or more persons 65 years of age or over. Carrying out this laborious study will be dependent on the availability of funds and of qualified assistants. In this study and in the other projects carried out in the survey area, the more intensive study will be extended, when indicated, to other regions for the accumulation of supplementary or comparative data.

Other Studies.—Among the other projects to be considered by this sub-committee is a study of insurance for illness of the aged. Information as to the present availability of hospitalization or sickness insurance and the cost of these for the protection of the aged will be sought. This study will be made by Mr. W. Harold Parham, the secretary of the Governor's Committee.

SUB-COMMITTEE NO. 2: COORDINATION AND MAXIMUM UTILIZATION OF STATE AGENCIES RENDERING HEALTH SERVICES. — The members of this committee are Dr. Edward Jelks, chairman, Drs. Edson J. Andrews, Leffie M. Carlton Jr., Edward W. Cullipher, Francis T. Holland, John D. Milton and Richard G. Skinner Jr. The study plan includes ascertaining the name and total number of state agencies rendering health services, the total number of employees by category, the services rendered, the source and amount of funds, the per cent of funds expended for services and the amount of services, the per cent of funds expended for administration, the composition of controlling authority, the type of medical service rendered, the criteria for determination of eligibility, the selection of vendor or personnel rendering services, the method and rate of payment for services, controls on the program, medical supervision and a summary of resources available. These data will be analyzed and appropriate recommendations made.

SUB-COMMITTEE NO. 3: ROLE OF VOLUNTARY HEALTH AGENCIES OPERATING IN FLORIDA. — Dr. Robert L. Tolle is chairman of this committee, and the other members are Drs. Thomas W. Dorr and William M. C. Wilhoit. The role of Florida's voluntary health agencies will be studied by seeking information in regard to the name and total number of such agencies, the services rendered, the source and amount of funds, the per cent of funds expended for services and for administration, whether national, state or local control, the amount of funds for national, state or local use, the composition of controlling authority, the type of medical service rendered, the criteria for determination of eligibility, the selection of vendor or personnel rendering services, the method and rate of payment for services, controls on the program, medical supervision and a summary of resources available. Recommendations will be made after analysis of the data obtained.

SUB-COMMITTEE NO. 4: MAXIMUM UTILIZATION OF HEALTH PERSON-

NEL. — Composing this committee are Dr. Wilson T. Sowder, chairman, Mr. Steve F. McCrimmon and Dr. Homer L. Pearson Jr. Study will be limited essentially to obtaining basic and statistical information from the various agencies and associations involving health personnel. When the information has been accumulated by staff assistants and summarized, it will be submitted for analytical review by the committee members. On the basis of the data obtained from this study, it would then appear possible that the report of this committee could include certain specific recommendations relative to the advisability of establishing a central information and placement service for all health personnel.

In brief, the proposed study outline includes listing the various classifications of all personnel engaged in rendering health services, both professional, licensed and unlicensed, and paraprofessional (paramedical); listing all licensing boards and associations involved; listing the number of licensed or registered health personnel by category, together with the job possibilities or position vacancies, and the type of employment available, full or part time, private, governmental and institutional; listing licensing boards and associations offering placement services and determining the scope of placement services; and surveying educational programs for health personnel as to the number of scholarship awards, the number of direct monetary grants, and the sources and amount of funds, and also as to job placement of recipients of scholarship awards or grants covering the number of recipients placed in employment within the state and the number employed out of the state.

PROGRAM PROGRESS.— Before the initial meeting of the Governor's Citizens Medical Committee on Health was adjourned, Dr. Hampton mentioned that in April 1959 the federal government will offer and make available approximately 10 million dollars to the State of Florida for the financing of vendor type programs for medical care of categorical indigents. It was accordingly recommended that the committee's study be completed and the report prepared with specific recommendations prior to January 1959 in order to have factual information available for presentation to the legislature when it is confronted with the federal proposal.

The next general meeting of the committee will be held during the month of September at the State Board of Health in Jacksonville. Meanwhile, the sub-committees are meeting as their various activities require, and all will meet one day prior to the general meeting next month.

This ambitious and constructive program, fostered by the Florida Medical Association and initiated with enthusiasm by Governor Collins, seeks to promote and protect the health and welfare of the citizenry of Florida. It should command hearty approval throughout the state and the utmost in cooperation.

Dr. Annis Addresses Audio-Visual Conference on Mental Health

A featured speaker on the program of an Audio-Visual Conference held at Florida Southern College in Lakeland in June was Dr. Jere W. Annis of that city, the newly installed President of the Florida Medical Association. His subject was "Guidance and Mental Health in a Changing Culture."

Viewing today's abundant but increasingly complicated life as demanding greater individual mental and emotional adjustment than life in any period the world has previously known, Dr. Annis cited the release of atomic energy as one example of man's pressing problems. He pictured man, like the many-headed monster Hydra, now seemingly confronted with 10 new problems for each one that is eliminated in the more complex civilization which he himself has created.

"Today, as never before," he commented, "the masses of the people are thinking about and expressing opinions regarding the ideologies of the great nations. Today we in the West wrestle with problems, with questions, and with answers which tend to reconfirm our faith that our democracy is the best form of government—the best 'way of life.' And the West's very existence may well hinge on our ability to competently criticize ourselves. To do this takes integrity and intelligence—takes the courage of our considered convictions.

"The fact that this very serious problem is of real interest to the large masses of people is exemplified by the tremendous popular acceptance of such figures as Norman Vincent Peale, Billy Graham, Bishop Sheen, and others. It indicates to me without question that people do earnestly seek Sir William Osler's 'aequanimitas.' It is evident that today—more than ever—we need a strong sheet-anchor in the seas of mental turmoil and strife; that we need, as never before,

a way of life—an equanimity—a sturdiness of emotion and spirit—to guide us through the rugged times in which we live. This much is essential, whether it be based on religion, philosophy, or whatever we may choose to call it."

Describing conflict between the individual personality and the environment as the essential basic unit of trouble disturbing our nervous and emotional stability, Dr. Annis said: "One might liken this struggle between our personality and our environment to a situation in which our personality is represented as a man—a man whose stature and toughness vary individually—a man who may be a midget or a giant—a man whose height may be three feet or seven feet. Somewhere between these two extremes each of us will find our own personality stature.

"Our environment, on the other hand, may be represented by a weight, or a bar-bell, which each of us has to lift. It may be a very light weight, indeed, if our environment is an extremely favorable one. It may weigh only a pound or two; or it may be a weight that is in excess of a thousand pounds and would crush any man beneath it. Somewhere between these two extremes lies our environment.

"And so the size of the man, and the size of the weight, at any one given moment, determine the resolution of the conflict or the struggle—determine whether he can hold this weight high above his head in complete victory and success—or whether it will bow him down and press him flat to the floor in complete submission and utter failure. And since, in today's life, we have many aids and adjuncts to our armamentarium—many things which will help us to lift this weight—and many things which, though pleasurable, will weaken us in our own ability to lift it, we have, therefore, a most complex and variable problem in which, truly, the importance of guidance and of mental health cannot be overemphasized."

With more than half of the hospital beds in this country devoted exclusively to patients with nervous and mental diseases, some 700,000 in all, and over 10 million persons having serious personality disorders, the magnitude of the problem is apparent. In seeking a solution, Dr. Annis would "formulate a program in such a way that we can provide a feeling of personal growth and expansion, and the attainment, finally, of the maturity that gives us significance as an individual and the dignity that is man—a maturity which may be partially defined as the tendency to give others a higher priority than ourselves—the sense of altruism and love for others that brings serenity, peacefulness and calm to the troubled waters that surround us." In such a program audio-visual aids have a useful role in meeting "this basic and fundamental problem of adjustment to a difficult environment" and in promoting "the establishment of a proper sense of values and the proper relative importance of the fundamental basic factors in our lives."

Postgraduate Obstetric-Pediatric Seminar

The Postgraduate Obstetric-Pediatric Seminar will be held for the eighth consecutive year in Daytona Beach at the Daytona Plaza Hotel. The dates will be September 8, 9 and 10, 1958. This continues to be one of the most popular meetings of its type in the southeastern United States. There is no registration fee.

As in the past, the program will consist of formal presentations on obstetric and pediatric subjects of current interest by some of the nation's leading medical figures. In addition, there will be the usual panel type discussion of questions submitted by the audience to a panel of experts. The meeting is of particular interest to pediatricians, obstetricians, gynecologists and those in general practice.

The seminar is jointly sponsored by the Bureaus of Maternal and Child Health of the State Health Departments of Florida, Georgia, South Carolina, and Alabama, the Maternal Welfare Committees of the four State Medical Associations, and the Florida Academy of General Practice. It is approved by the American Academy of General Practice for 15 hours' credit in Category I.

Doctor's Role in Community Disaster

Entitled "Your Doctor's Role in a Community Disaster," a pamphlet recently published by the Broward County Medical Association seeks to clarify the physician's role in a disaster to the general public. It represents a progressive step which should evoke general interest among physicians. Dr. David J. Lehman Jr., chairman of the association's disaster committee, announces a plan to make this an annual publication.

In some parts of the country, the physician's role in a disaster has been well publicized. In Broward County, however, and in other parts


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of South Florida, the disaster chairman and the officials of the Broward County Medical Association believe the importance of the physician in such an event has been known only to a few physicians in the local medical organizations. As a much needed public relations measure, therefore, this pamphlet was published in an effort to familiarize the members of the county medical society, members of lay disaster groups, and the general public with the physician's role.

The information is for the guidance of all concerned. The organizations essential to the proper handling of casualties and their chief functions—Civil Defense, American Red Cross. local community disaster units, nursing service, medical service, communications, and community police department—are listed first. The remainder of the pamphlet is devoted to the duties of the various physicians of the association at the time of a disaster, and a duty roster of medical shelters throughout Broward County is included.

Physicians receiving requests to speak before lay groups regarding their role in a disaster are urged to accept. Information will be supplied to them by the chairman of the disaster committee.

This timely public relations project of the Broward County Medical Association merits both commendation and emulation.

Florida Diabetes Association Meeting Miami Beach, Oct. 30-31, 1958

The Florida Diabetes Association will hold its 1958 meeting on October 30 and 31 at the Balmoral Hotel in Miami Beach.

The outstanding out-of-state speakers who will participate in the two day program are Dr. Howard F. Root of Boston, Dr. Thomas F. Frawley of Albany, N. Y., and Dr. James B. Field of the National Institutes of Health, Bethesda, Md. In addition, there will be participation by staff members of the medical schools of the University of Miami and the University of Florida.

The subject matter will include topics of interest concerning recent developments in the understanding and management of patients with diabetes mellitus. Current data on the exceedingly common types of insulin resistance encountered in patients with diabetic acidosis and also the type of patients receiving exogenous insulin will be presented. Vitamin metabolism in patients with defects of carbohydrate metabolism will also be discussed. In addition, there will be talks devoted to specific problems in clinical endocrinology apart from those involving carbohydrate metabolism.

Detailed programs and other pertinent information will be sent to all physicians in the state. All interested members of the medical profession are urged to make plans to attend this seminar.

Crusade for Freedom

"Just at this moment, when developments on the other side of the Iron Curtain clearly show that the yearning for freedom remains alive and vibrant, it is particularly important that the Crusade continue its effective work. . . . Wide contributions by American citizens and American enterprise are essential."

This is an excerpt from a speech given by President Eisenhower at the beginning of the 1958 Crusade for Freedom fund-raising drive. The President launched the first Radio Free Europe campaign in 1950. July 4, 1958, will mark the eighth year that Radio Free Europe has been broadcasting truth to peoples behind the Iron Curtain.

Heading the Florida Crusade for 1958 is Gov. LeRoy Collins, Honorary Chairman. Commissioner J. Edwin Larson, State Treasurer, is the campaign director, and Timothy J. Sullivan, Community Relations Director for the Florida Power and Light Company is vice-chairman.

WHAT IS CRUSADE FOR FREEDOM? It is the organization which supports Radio Free Europe, a wholly American, privately supported effort to send truth to the other side of the Iron Curtain.

Radio Free Europe is an extensive system of 29 powerful transmitters and relay stations, located in West Germany and Portugal. It sends news, entertainment, religious programs, music, and cultural programs into five key satellite countries: Poland, Hungary, Rumania, Bulgaria and Czechoslovakia, for as many as 20 hours a day.

WHO WORKS FOR THE CRUSADE? At the beginning of each year's campaign, its director, Commissioner Larson, has asked several prominent men to be subchairmen in their respective fields. This year, Attorney General Richard M. Ervin, Mr. Clarence M. Gay, President of the Citizens National Bank of Orlando. and Mr. Bryon S. Herlong, President of the State Motel Association, are listed among the many public-

spirited Floridians who are helping in this cause of freedom.

What do the listeners think of Radio Free Europe? It may sound like a good thing here, but is it accomplishing its purpose? The Russians seem to think so. The Kremlin is so afraid of the programs that it spends millions each year to operate "jamming stations." The system, however, has transmitters all aimed at the same spot, and it is practically impossible for the Russians to "jam" the broadcasts completely.

The greatest testimonials come from the listeners themselves. Thousands of European refugees are interviewed each year, and letters actually come from behind the Iron Curtain, carrying friendly comments on programs, making requests, and even offering small criticisms. What Radio Free Europe means to its listeners can be summed up in the words of a Polish listener:

"In you we find great moral support. You teach us to look into the future calmly and sensibly and prevent the world from forgetting that we are still waiting for full and real freedom. You are playing a great historic role, the importance of which no one today is able to sufficiently appreciate."

The present campaign is of the utmost importance. Those who would like to make a private contribution to the Crusade for Freedom may do so by sending their check to Mr. Harry G. Retalick, Executive Vice President, First National Bank of Miami, 101 E. Flagler Street, Miami. Mr. Retalick is the State Treasurer for the Florida Crusade for Freedom.

Florida Medical Association Golf Tournament

The annual Florida Medical Association Golf Tournament was held at the Westview Country Club on Miami Beach during the Association's recent Anuual Meeting at Bal Harbour.

Dr. Julian A. Rickles, of Miami, chairman of the Golf Committee, reported that the number of entries was smaller than for the tournament last year at Hollywood Beach, but that overall the tournament was a success. Assisting Dr. Rickles were Drs. Maxwell M. Sayet and Sanford Levine, Miami Beach, and Truxton L. Jackson, Miami.

Dr. Joseph L. Hundley, of Orlando, and Dr. Henry H. Bryant III, of Coral Gables, tied in competition for the Orlando Loving Cup. Lots were drawn to break the tie and Dr. Bryant was declared the winner.

Dr. William G. Meriwether, of Plant City, and Dr. Edson J. Andrews, of Tallahassee, had identical scores in play for the Duval County Medical Society Trophy. In a match, Dr. Andrews won the Trophy.

OTHERS ARE SAYING

The Patient's Family

In our eagerness to make the proper diagnosis and to institute the proper treatment, we are at times likely to overlook an important part of the patient—his *family*. We forget that the patient is *not* just a man or a woman with a disease and that he usually represents an integral and much-loved part of a family unit. Consequently, we cannot expect to take such a person, place him in a hospital for treatment, and at the same time divorce him, as well as ourselves, completely from his family and those who love him, shunning all contact with them as if they were infected with the plague or pestilence of years gone by.

A nurse once made the statement, "If he (the patient) doesn't tire you out, his family will," as the doctor was preparing to visit a hospital patient with incurable cancer. It had never occurred to this nurse how important the patient is to his family, and how important the family is to the patient. She never realized the mental anguish of the mother and daughter as they sat with the patient day by day, hopelessly watching him grow weaker, and knowing that nothing could be done to save him from death soon to come. The questions asked by the family relative to the patient's status were interpreted as being "nosey." The simple requests to make the patient more comfortable during his last days were regarded as attempts to interfere with the duties of the nurse, or as impositions. She had never stopped to visualize herself as being in the place of the unhappy wife or daughter, and to think how she would feel if she were in their situation. In reality she had never understood or believed in the *Golden Rule*.

We as physicians are in danger of finding ourselves laboring with the same attitude as this

nurse. The questions asked by the family may seem too simple or even foolish, and the same questions may be repeated day after day. As death comes closer, the questions may seem less logical, even bordering upon hysteria. It is here that a little patience and kindness by the doctor can do an untold amount of good in dealing with the family as well as the patient. Uncertainty and the lack of knowledge are basic ingredients in the formation of fear, and the doctor can do much to quell a rising fear.

On the other hand, the patient may have some relatively simple condition which can be cured without difficulty. Here again, we should remember that his family is vitally interested in his welfare and we should not hesitate to keep them informed as to his progress.

Occasionally the size of the family can become a major problem for the doctor, for if each member of a large family individually calls the doctor for information regarding the condition of the patient, a valuable amount of the doctor's time may be unnecessarily spent. This problem can usually be overcome by calling the family together, singling out a single responsible and intelligent member, and appointing him to act as liaison between the doctor and the remaining members of the family. The doctor can then keep this member informed as to the situation, this person in turn relaying the information to the others. In this way many unnecessary telephone calls can be avoided.

In conclusion, we should keep in mind that the patient is *not* an isolated individual and that he is but a part of the family unit; hence we should treat him and his family as a whole. By doing so, we automatically better our public relations, for a dissatisfied family can undo all the good we may have accomplished in a satisfied patient.

R. C. P.
Monthly Bulletin
Duval County Medical Society
April 1958.

Florida Medical Association Eighty-Fifth Annual Meeting

The date of the 1959 Annual Meeting of the Florida Medical Association has been announced as May 2-6. It is scheduled for the Americana Hotel in Bal Harbour, a section of Miami Beach.

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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

STATE NEWS ITEMS

The Ninth Annual Scientific Assembly of the Florida Academy of General Practice is scheduled for October 30-November 1 at the George Washington Hotel, West Palm Beach. Dr. Cecil M. Peek of West Palm Beach is general chairman.

A one day course in "Cardiac Resuscitation" is being held October 3 at the Emory University School of Medicine, Atlanta. The visiting faculty includes Dr. Paul Zoll, Beth Israel Hospital, Boston, and Dr. David S. Leighninger, Lakeside Hospital, Cleveland. Information may be obtained by contacting Postgraduate Education, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 3, Ga.

Construction has begun on the $2,150,000 Medical Research Unit of the University of Miami School of Medicine. The eight story structure will house laboratories for all phases of medical research, and the first unit of the permanent medical library. Completion date is estimated at 15 months.

Dr. Wendell J. Newcomb of Pensacola has been appointed to the board of directors of the Florida Arthritis and Rheumatism Foundation for the northwest Florida district.

Dr. Theodore F. Hahn Jr. of DeLand attended the recent annual meeting of the American College of Physicians held at Atlantic City. He also attended the 30th reunion of his class at Yale University.

Dr. Ashbel C. Williams of Jacksonville has been elected a member of the board of directors of the American Cancer Society. He will represent region three which is composed of nine southern states.

The fourth postgraduate course in esophageal speech and organic voice problems was held at the University of Miami School of Medicine June 16-27. Director of the course was Dr. Nathaniel M. Levin, Assistant Clinical Professor of Otolaryngology. Sixty persons representing university and hospital speech departments attended.

Dr. I. Leo Fishbein of Miami Beach sailed from New York June 27 for an extended tour of the Mediterranean area, India, Pakistan and Ceylon. He will visit medical and psychiatric institutions in these countries.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, will address members of the Sarasota County Medical Society at a meeting September 9.

Dr. George H. Miller Jr. has been appointed Associate Professor of Surgery and Chief of the Division of Urology at the College of Medicine, University of Florida, Gainesville. Dr. Miller was formerly Associate Professor of Urology at the School of Medicine, University of Chicago.

Dr. Mozart A. Lischkoff of Pensacola boarded the S. S. Statendam in New York June 14 for a trip to Stockholm where he attended a sectional meeting of the American College of Surgeons early in July. He will return the latter part of August.

Dr. Erasmus B. Hardee of Vero Beach, president of the State Board of Medical Examiners, has been elected a member of the executive committee of the National Board of Medical Examiners.

Dr. William W. Schildecker of Daytona Beach was one of the principal speakers at the 21st Annual Assembly of the Southeastern Hospital Conference held recently at Miami Beach.

"Daybreak," a new novel by Dr. Frank G. Slaughter of Jacksonville, has been published by Doubleday & Co. The book has been described as Dr. Slaughter's "finest medical novel since he laid aside scalpel for pen."

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The United States Section of the International College of Surgeons has arranged with the faculty of the Cook County Graduate School of Medicine, Chicago, for the presentation of a second postgraduate course October 13-25. Information may be obtained from the International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Drs. John J. Meli of Naples and Joseph W. Lawrence of Fort Myers are serving on the advisory committee for the Collier County Tuberculosis and Health Association.

Dr. Charlotte E. Mason of Hollywood has been elected president of the recently formed Broward County Chapter of the American Medical Women's Association.

Dr. Louis J. Novak of Hollywood has been installed as president of the Heart Association of Broward County. Other officers include Dr. Marshall C. Sanford of Fort Lauderdale, first vice president, and Dr. Beverly R. Birely also of Fort Lauderdale, second vice president.

Dr. Francisco A. Hernandez of Miami has been given an award by the Florida Heart Association for research studies on "Retrograde Catheterization of the Left Ventricle by Way of the Brachial Artery and Ascending Aorta."

Dr. Alvan G. Foraker of Jacksonville has returned from Europe where he attended the Seventh International Cancer Congress held in London and lectured on various phases of cancer research and cell studies at the gynecology clinic of the University of Paris and the institute of pathology at the University of Milan. At the Cancer Congress, Dr. Foraker presented a paper on "Nuclear Mass and Allied Phenomena in Orientation of Intraepithelial Carcinoma of the Cervix Uteri" and a film entitled "Medical Research in a Community Hospital."

Dr. Richard C. Cumming of Ocala has been elected district governor for that area by Rotary International in convention at Dallas, Texas.

Dr. John E. Emlet of Pensacola was principal speaker at a recent meeting of the Exchange Club

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of that city. He was introduced by Dr. William P. Hixon also of Pensacola, the Club's program chairman.

Dr. Winston L. Summerlin of Gainesville has returned from Mexico City where he attended the Pan American Congress of Obstetrics and Gynecology.

Dr. Eugene D. Liddy Jr. of Sarasota has been re-elected to the board of directors of the Sun Coast Heart Association.

Dr. Gretchen V. Squires of Pensacola was principal speaker at a recent meeting of the Exchange Club of that city. Dr. Squires discussed diseases contracted by patients from hospital dust and from other patients with contagious diseases.

Drs. Fairfax E. Montague and Claude M. Knight of Palatka have been selected as directors for the newly organized Putnam County Blood Bank.

Dr. John A. Dyal Jr. of Perry related incidents in the history of medicine and surgery at a mid-June meeting of the Rotary Club in that city.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Donald B. Frazier of Jacksonville announce the birth of a daughter, Virginia Goodwin, on May 4, 1958.

Dr. and Mrs. Dominic A. Bianchi of Jacksonville announce the birth of a son, Patrick Deverell, on April 10, 1958.

Marriages

Dr. Vincent Coppola Jr. of Fort Lauderdale and Miss Lillian Bussolin also of Fort Lauderdale were married May 17, 1958.

Deaths—Members

Hodgins, Thomas E. Jr., Jacksonville	June 22, 1958
McClellan, George S., Pompano Beach	June 22, 1958
Warren, George H., Perry	May 30, 1958
Elarbee, George W., Pahokee	May 26, 1958
Martin, Douglas D., Tampa	May 24, 1958
Smith, James S., Miami	May 17, 1958
Vinson, John C., Fort Myers	June 10, 1958
Steinman, William, Miami	February 10, 1958

Deaths—Other Doctors

Arnow, Matthew, Eustis	December 29, 1957
Floyd, Hayden G., (Col.), Gainesville	August 3, 1957
Crump, James E., Winter Haven	April 15, 1958
Hall, Fairfax, Virgin Islands	June 4, 1958
Styles, George W. (Col.), Miami	June 4, 1958
Williams, Edwin L., Fort Meade	June 1, 1958
Wilson, Talmadge S., Stuart	June 15, 1958

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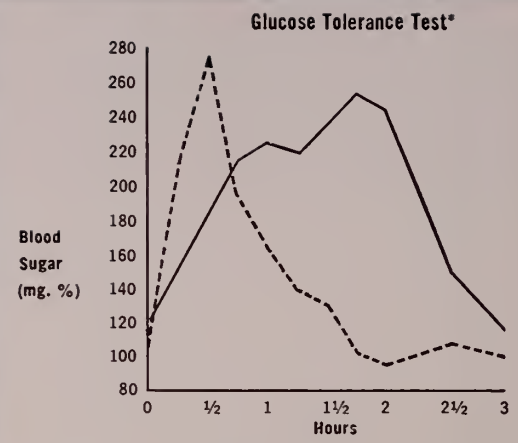
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WANTED: General Practitioner and Pediatrician to join group who owns thirty bed hospital. Consulting service once a week. Academic environment. Salary first six months partnership later. Must be draft exempt. Florida license required. Write 69-275, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: Internist. Board qualified. Special training in chest diseases. Florida license. Desires association with Internist or group. Prefer central Florida. Write 69-266, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner and Board certified Otolaryngologist to associate with well established medical group in growing community, Florida East Coast. Florida license required. Salary first year with partnership privileges to follow. Send full details, training, experience, character reference, etc. in first communication. Write 69-276, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner, must be under 32 years of age. Contact Daniel Clinic, Titusville, Florida.

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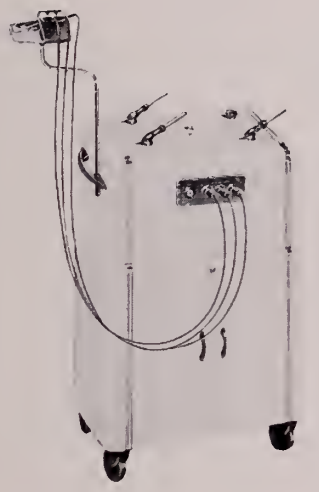
Brevard

Dr. Edward R. Woodward, of Gainesville, Chairman of the Department of Surgery at the University of Florida College of Medicine, was principal speaker at a June meeting of the Brevard County Medical Society. It was held at the home of Dr. Jack T. Bechtel in Eau Gallie, president of the Society.

Dr. Woodward presented a progress report on the J. Hillis Miller Health Center and the associated colleges of pharmacy, nursing and rehabilitation.

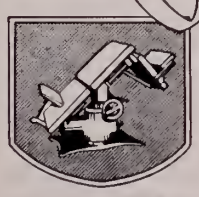
Broward

Members of the Broward County Medical Association honored the retired physicians in the county at a dinner meeting held May 27. Dr. Leon Herman, formerly Professor of Urology at the University of Pennsylvania School of Medicine, was principal speaker of the evening. Signally honored was Dr. Henry O. Wells, who at 93 is the oldest retired physician in the county.



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Dade

Mr. C. B. Kniskern Jr.. an attorney, was principal speaker for the June meeting of the Dade County Medical Association. The subject of his address was "The Physician and His Will."

Escambia

Mr. Ray Phillips, superintendent of Sunland Training Center at Gainesville, addressed the members of the Escambia County Medical Society at a meeting held the first part of June.

Hillsborough

Dr. Harold Carron, of Tampa, discussed hypnosis at the June meeting of the Hillsborough County Medical Association. The title of his address was "Hypnosis as a Valuable Adjunct to Your Present Armament."

Lake

Dr. Curtis M. Phillips Jr., of Jacksonville, was principal scientific speaker at the June meeting of the Lake County Medical Society held at Howey-in-the-Hills. Dr. Phillips discussed "Carcinoma of the Breast."

At the business meeting following the scientific program, Dr. Fred A. Vincenti, of Mount Dora, presented the highlights of the annual meeting of the Florida Medical Association at Bal Harbour. Dr. Vincenti is the Society's delegate. Various other matters of business were discussed including an active public relations program which is being put into effect very shortly.

Lee-Charlotte-Hendry

Dr. Michael J. Jordan of Memorial Hospital in New York was guest speaker at a May meeting of the Lee-Charlotte-Hendry County Medical Society held at Fort Myers. Dr. Jordan discussed the "Present Status of Carcinoma in Situ."

Dr. James N. Patterson, of Tampa, a member of the Board of Governors of the Florida Medical Association. was principal speaker at the Society's June meeting also held at Fort Myers.

Madison

The Madison County Medical Society has paid 100 per cent of its state dues for 1958.

Orange

Dr. Lorant Forizs, of Avon Park, clinical director of the State Alcoholic Rehabilitation

(Continued on page 218)



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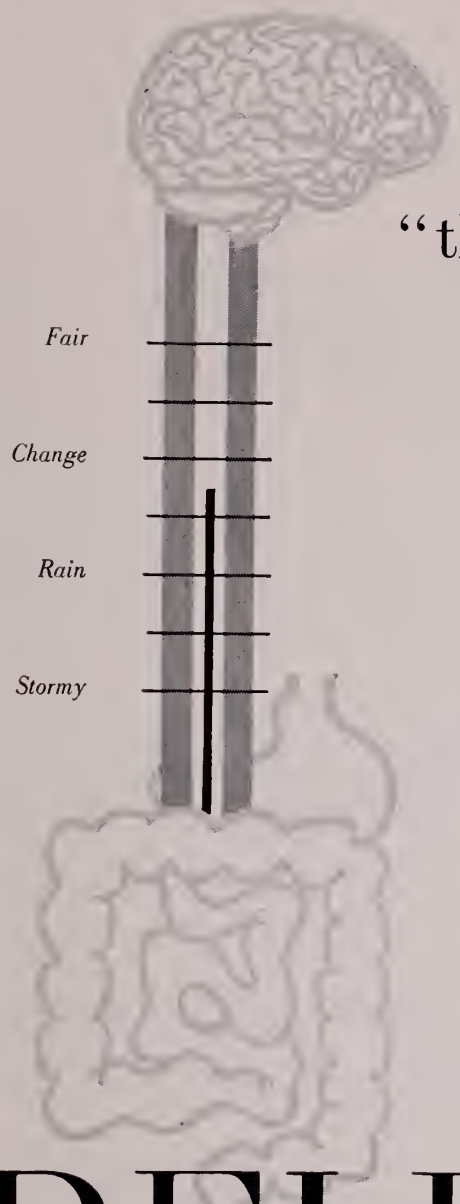
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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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9, April 1956. 179. Friedman, A. P.: The treatment of chronic headache with meprobamate. Use of tranquilizers in the treatment of headache. Am. Pract. & Digest Treat. 8:94, .M.A. 163:1111, March 30, 1957. 182. Friedman, H. T. and Marmelzat, W. L.: Adverse robamate [Miltown] - a clinical study. Am. J. Psychiat. In press, 1957. 184. Gibbs, Relaxant effects of meprobamate in disabilities resulting from musculoskeletal and 453, July 1956. 186. Gillette, H. E.: The effect of meprobamate on cerebral palsy. ers and purpura hemorrhagica (Correspondence). J.A.M.A. 161:96, May 5, 1956. 188. An evaluation of meprobamate in the treatment of alcoholism. Ann. New York Acad. Sc. "Habit-forming" individuals (Queries and Minor Notes). J.A.M.A. 163:515, Feb. 9, e. Ohio M. J. 52:1306, Dec. 1956. 192. Hollister, L. E., Elkins, H., Hiler, E. C. ad. Sc. 67:789, May 9, 1957. 193. Hollister, [illegible] Stannard, A. N. and Drake, C. F.: 194. Holoubek, J. E., Thomas, O. C. and [illegible] L.: [illegible] reaction to 2-methyl- 95. Karli[illegible] [illegible] [illegible] [



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

Roerig

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*Trademark

(Continued from page 212)

Program, was guest speaker at the June meeting of the Orange County Medical Society.

Pinellas

Lt. Col. George L. Shead, USMCR, of Dunedin, was guest speaker at the June meeting of the Pinellas County Medical Society. His general subject was moral rearmament.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abbey, Joseph E., Miami
Azen, Norman H., Miami
Brennan, Robert J., Fort Lauderdale
Brook, Karl Y. R., Opa Locka
Burns, David N., Miami
Caldwell, William T. III, Jacksonville Beach
Carter, Howard W., St. Petersburg
Church, Gaylord, Clearwater
Dolison, Dean M., Miami
Donegan, Charles C. Jr., Naples
Feigenbaum, David, Miami
Foard, Milton C., Leesburg
Getz, John L. Jr., Jacksonville
Gonzalez, Manuel A., Miami
Grimes, Dewey H., Chipley
Hembree, Joseph M., Miami
Hoover, George W., Fort Lauderdale
Howell, David S., Coral Gables
Kay, John H., Panama City
Kemp, Simon I., Miami
Lane, David C., Fort Lauderdale
Moore, Louis S., Naples
Mora, Modesto M., Miami
Munroe, Colin A., Hollywood
Osman, Daniel A., Miami
Pearce, Milton L., Opa Locka
Phillipp, Ernst A., South Miami
Rader, Luke R., Miami
Ritchie, John A., Jacksonville
Roche, Thomas W., N. Miami Beach
Rosen, Sigmund J., Miami
Rudolph, Arthur I., South Miami
Rush, Joseph C., St. Petersburg
Schechter, M. Murray, Miami
Scokel, Paul W. III, Jacksonville
Segal, Myron I., Miami
Smith, J. Graham Jr., Miami
Soshea, John W., St. Petersburg
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For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:
1 or 2 tablets.
Narcotic blank required.

Potentiated Pain Relief

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

References:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Formula: *each scored tablet contains: meprobamate 400 mg., tridihexethyl iodide 25 mg.*

Dosage: *1 tablet t.i.d. with meals and 2 tablets at bedtime*

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Safeguard Today's Health for Tomorrow

One of the main objectives of the Woman's Auxiliary to the Florida Medical Association is to aid the doctor's in reaching their objectives and in promoting better relations between the doctor's family and other families in the community. They lead, and the Auxiliary is the link which unites us with other individuals and our organizations with other forces concerned with the health of our nation.

We have chosen as our theme this year "Safeguard Today's Health for Tomorrow." Our priority projects include American Medical Education Foundation, Recruitment, Today's Health and Safety.

The American Medical Education Foundation was organized because of the concern of our doctors in furthering medical education. The Foundation was established in 1951 by the American Medical Association. It is dedicated to the private support of medical education in this country. The Auxiliary has been aiding in this project since 1952. It is the desire that each auxiliary will realize the need and give toward this project. Much can be accomplished through unity. Your individual contribution is always needed; it will be your investment in the future of medicine and will help keep our medical schools debt free.

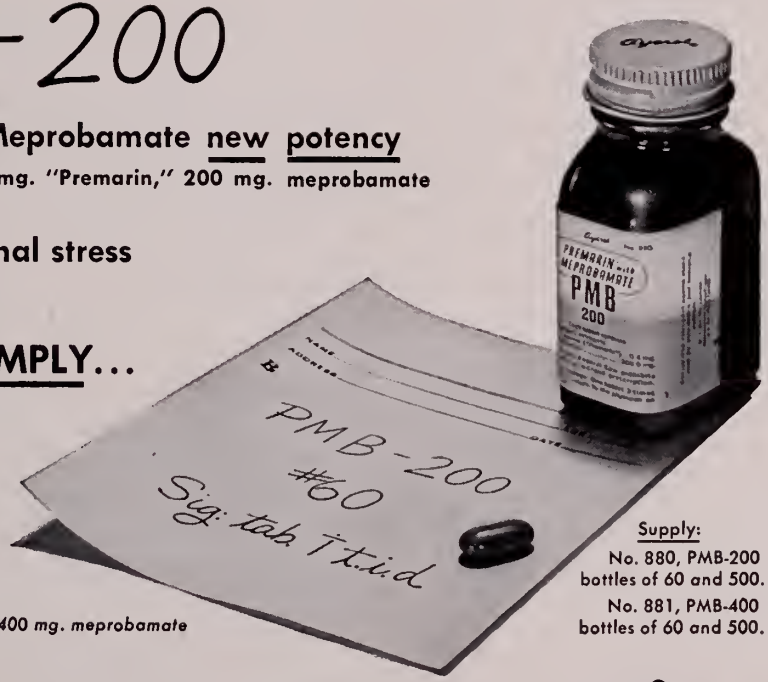
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Each tablet contains 0.4 mg. "Premarin," 200 mg. meprobamate

For undue emotional stress
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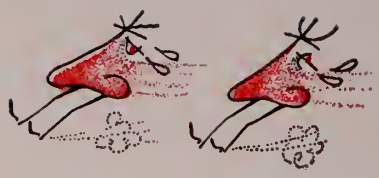
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running noses . . . and other hay fever symptoms



TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

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Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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many ways in which Auxiliary members may aid in this project. This health magazine is one of the best means of making the public conscious of health education. Each group should first of all see that each member is a subscriber. Then, a simple practice of passing the magazine on to a neighbor is such an easy habit to form. Place subscriptions to Today's Health on your gift list, and by all means see that it is read in your doctor's waiting rooms. This is an excellent health magazine, and let's make an all out effort to make our friends and neighbors aware of it.

Much has been done already in the field of recruitment in the Future Nurses Clubs all over the state, but we cannot stop there. There are many other ways in which we can interest our youth in medicine.

The shortage of nurses has always been acute, but there are many other fields in which we may be able to interest the students by working with the high schools, PTA's, Red Cross, hospitals, and Y.W.C.A. We can work closely with the Vocational Guidance Counselors in the high school in aiding the students in making up their minds as to their suitability for a medical career. Remember, we are the link between the doctor and the people of the community and it is up to us to seek every opportunity to promote interest in the future of our health.

There has never been a time when we as a nation should be more conscious of the need for the priority project "Safety." One only has to read the daily newspaper to realize the needless waste of human lives. There are so many ways we may promote safety. Some high schools now have driver education courses. Where these have not yet been started we should make plans immediately for getting them into effect. We need to familiarize ourselves with them in order to be more informed on the subject. More is needed in safety on our beaches, safety in the home, protection of small children from home tragedies, such as swallowing insecticides or contents of unlabeled bottles. And certainly we should all promote safety through physical and emotional fitness in our families and our communities.

We should be interested in promoting in our legislature more laws that will permit tests for intoxication, and make the penalties such as to wipe out the drunken driver - one of the greatest menaces on our highways today. Remember, more can be accomplished working as a unit. Work with other groups interested in the promotion of safety,

(Continued on page 228)



for adults and children



Prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
Exempt Narcotic. Available on Prescription Only.

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PREVENT
both cause and fear of
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ATTACKS

proven safety for long-term use



Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®**
The *original* meprobamate, discovered and introduced by Wallace Laboratories

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sustained coronary vasodilation with **PETN**
pentaerythritol tetranitrate
a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 13B

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

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Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



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multiple compressed tablets

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THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



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MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation...

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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.



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(Continued from page 223)

such as Woman's Clubs, men's civic groups and PTA.

Let us give more serious consideration to our priority projects for this year. Organize within your group. Make an all out effort to promote these projects in every possible way. Let our national theme be our motto: "Safeguard Today's Health for Tomorrow."

Mrs. Albert F. Stratton Jr.

OBITUARIES

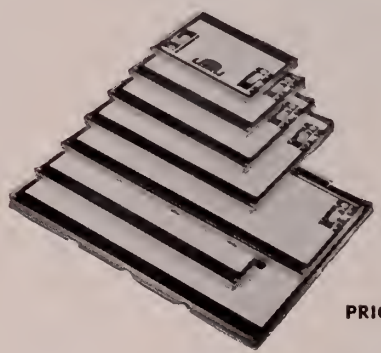
Benjamin Joseph Bond

Dr. Benjamin Joseph Bond of Winter Haven died suddenly of coronary thrombosis at his home Feb. 28, 1958. He was 50 years of age.

A native of Canon, Ga., Dr. Bond was the son of Mrs. Fanny Bond and the late Dr. Benjamin Franklin Bond. He received his academic schooling and also his medical training at Emory University, where he was graduated from the School of Medicine in 1932. He was a member of the Sigma Nu social fraternity and the Phi Chi medical fraternity. After completing an internship of one year at Emory University Hospital, he served his residency at St. Joseph's Hospital in Savannah, Ga.

In 1934, Dr. Bond entered the private practice of general medicine with emphasis on surgery in Florida, locating in Winter Haven. He continued to practice there for almost a quarter of a century except for the period during World War II when he served in the United States Navy as a flight surgeon with the rank of lieutenant commander. In 1949 he became one of the co-founders of the Bond Clinic. He was a member and a past president of the medical staff of the Winter Haven Hospital and was the local surgeon for the Seaboard Air Line Railroad. A thirty-second degree Mason, he was a member of the local F. and A.M. Lodge 186, the Winter Haven Knights Templar Commandery No. 37, the Tampa Consistory of the Scottish Rite and was a charter member of the Bahai Temple Shrine in Orlando. He also held membership in the Winter Haven Elks Lodge 1672, the American Legion Frierson-Nichols Post, the Polk County Voiture 218 and the 40 and 8, the Winter Haven Boating Club, and the Winter Haven Rifle Club. He was a charter member and a past president of the Lions Club. Since 1934 he had served as physician to the local high school

G-E molded cassettes cost less— last far longer!



Molded-rubber frame cushions jolts, keeps front and back of cassette in *true alignment*. Built-in glass-fiber pad gently squeezes screens and film for uniform contact always. "Slide-easy" latches release at light finger pressure, resist accidental opening. Molded-rubber seal prevents entry of light. Exclusive rubber hinge — thoroughly proved in ½-million flexings that left it *bonded as firmly as at time of manufacture!*

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BONADOXIN brings relief to 88.1% of patients...often within a few hours.[1,2] But it does not produce drowsiness, or side effects associated with over-potent antinauseants. With safe BONADOXIN, "toxicity and intolerance...[is] zero."[2]

Is she blue at breakfast? Prescribe BONADOXIN. Usually just one tablet at bedtime stops nausea and vomiting of pregnancy...

and just one supplies the full 50 mg. of pyridoxine. ⇦

EACH TABLET CONTAINS:

MECLIZINE HCl . . . . . 25 mg.
PYRIDOXINE HCl . . . . . 50 mg.
Bottles of 25 and 100.

References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

...and for a nutritional buildup plus freedom from leg cramps*

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phosphate-free calcium, 10 essential vitamins, 8 important minerals. Bottles of 100.

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athletic association. He was a member of the First Presbyterian Church.

Dr. Bond was a member of the Polk County Medical Association, of which he was a past president. He also held membership in the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Amelia Wolfe Bond, and three daughters, Miss Beverly Bond, Miss Anne Bond and Miss Barbara Bond, all of Winter Haven; his mother, Mrs. Fanny Bond, and a sister, Miss Ximena Bond, both of Savannah, Ga.; and three brothers, Charles Bond, of Anchorage, Alaska, and Steven Bond and William Bond, both of Savannah.

Marvin Sol Freedland

Dr. Marvin Sol Freedland of Miami died suddenly while at work in his office on March 8, 1958, succumbing to heart disease that had shadowed him for years. He was 35 years of age.

Born in Rochester, N. Y., in 1922, Dr. Freedland was educated in the schools of his native state. He attended public schools in Rochester, Franklyn Academy in Malone, and later the University of Buffalo. He then served his country in the Pacific Theater for four years during World War II. Upon completion of his military service he studied medicine at the Chicago Medical School, where he was graduated in 1951.

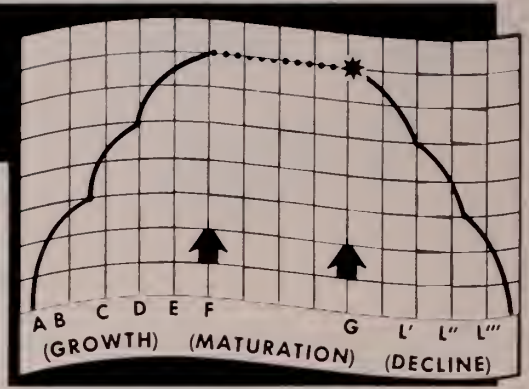
Dr. Freedland came to Florida in 1951 and served an internship at Jackson Memorial Hospital in Miami. He then engaged in the private practice of medicine in that city as a general practitioner. Locally he was a member of the Coral Way Jewish Center and he served the University of Miami School of Medicine as a clinical instructor of general practice for two years. His fraternity was Phi Lambda Kappa.

A member of the Dade County Medical Association, Dr. Freedland was also a member of the Florida Medical Association and the American Medical Association. In addition, he held membership in the Southern Medical Association and the American Academy of General Practice.

Dr. Freedland is survived by his widow, Mrs. Selma Freedland, two sons, Gary and Bobby, and his parents, Mr. and Mrs. Joseph Freedland, all of Miami; and two sisters, Mrs. Howard Albrecht of New Rochelle, N. Y., and Mrs. Joseph Alderman of Haddenfield, N. J.

...to postpone the "G" point*...

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For patients aver 40, The G POINT (paint of declinatian in life) can be pastpaned!

Praperly balanced Androgen — Estrogen — nutritianal therapy may prevent premature aging and damage af gonadal decline and nutritianal inadequacy.

Camplaints of symptoms such as muscular pain, fatigue, irritability, and poar appetite in the patient aver 40 may be the first indicatians of three major stress factars in the aging process: (1) Gonadal Harmanal Imbalance, (2) Nutritianal Inadequacy and (3) Emotianal Instability. GERITAG is especially farmulated ta guard against premature damage and ta delay the degenerative pracess.

Rx GERITAG in preventive geriatrics.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Methyltestosterone	2 mg.	Thiamine Hcl.	2 mg.
Ethinyl Estrodiol	0.01 mg.	Riboflovin	2 mg.
Ferrous Sulfote	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinomide	20 mg.
Ascorbic Acid	30 mg.	Monganese	1 mg.
B-12	1 mcg.	Mognesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitortrote	40 mg.
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Cal. Pontothenate	3 mg.		

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CREMOSUXIDINE gives prompt control of seasonal diarrhea by providing antibacterial and antidiarrheal benefit. It detoxifies intestinal irritants and soothes inflamed mucosa.

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Fish Soufflé



Vegetables



Herbs



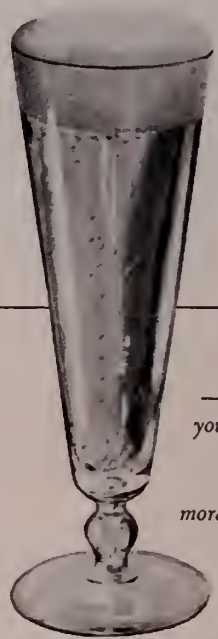
Salads



Applesauce Dessert



Potatoes



Variety in taste and texture of foods must become your patient's "Spice"

—and, with your consent, a glass of beer for a morale booster

The Bland Diet

• Meat patties stay tender when crushed corn flakes and water are added to the finely ground beef. Salt and a hint of thyme or marjoram give savor. Fish soufflé is a delight when the top is crisped with cracker meal and butter.

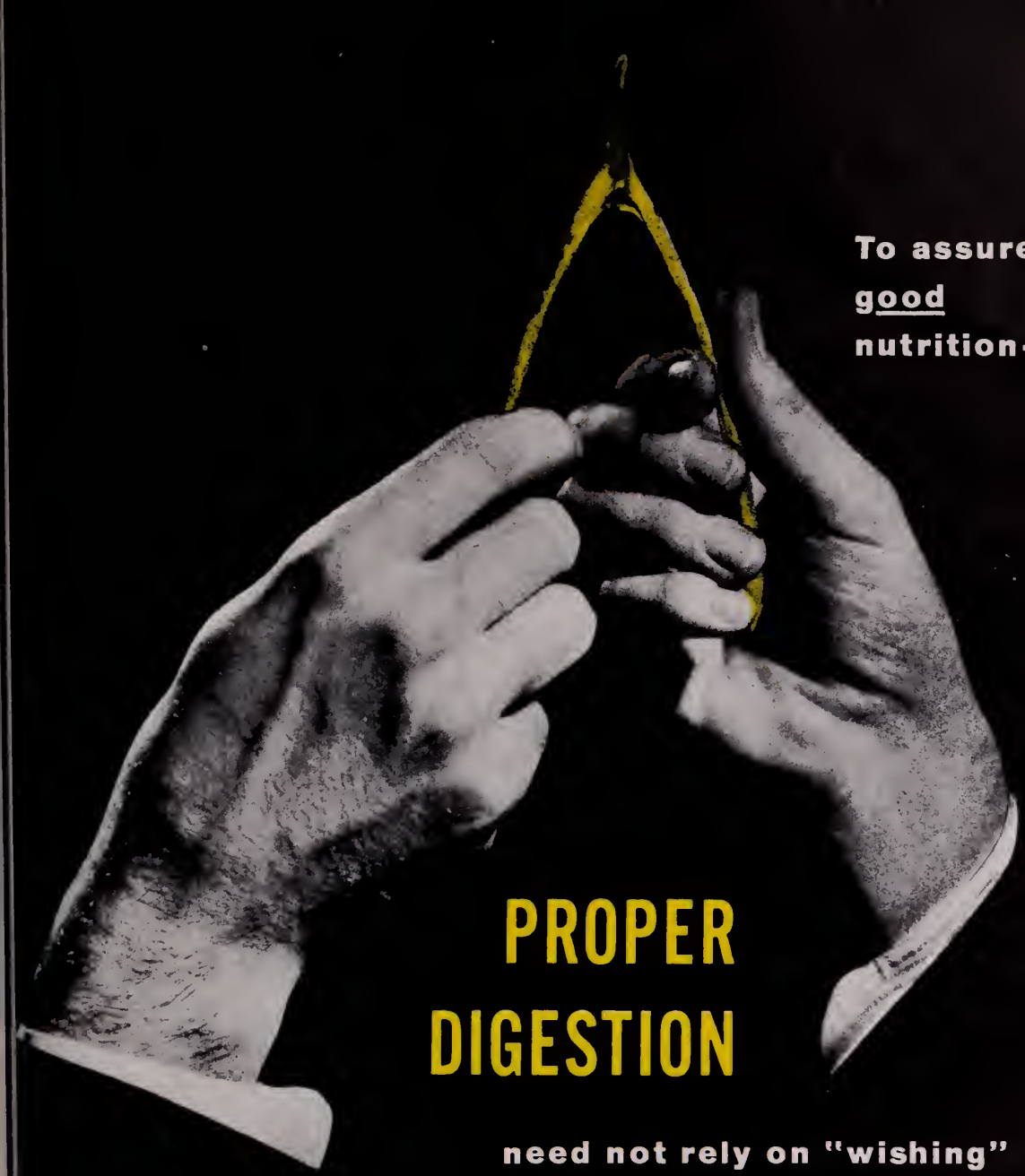
Vegetables such as tender, young string beans, peas, beets, and carrots may be cooked and served whole—otherwise puréed. Potatoes may be boiled, baked or mashed. Molded gelatin salads are pretty to look at—better to eat. For dessert, perhaps applesauce added to whipped lime gelatin, and topped with custard sauce.

And with a glass of beer*—at your discretion—your patient will find his diet interesting and ample without straying from instructions.

*pH—4.3 (Average of American Beers)

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Each double-layered Entozyme tablet contains:

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BOOKS RECEIVED

Laboratory Medicine—Hematology. By John B. Miale, M.D. Pp. 735. Illus. 192. Price, $13.75. St. Louis, The C. V. Mosby Company, 1958.

This book on Hematology is the first of a series of books on Laboratory Medicine and is intended to present laboratory aspects of medical practice for students and physicians. This present volume and two others in preparation on Chemical Pathology and Microbiology emphasize the correlation between laboratory and clinical data. The range is from basic mechanisms to the interpretation of laboratory data in diagnosis and therapy. The author points out in the Preface that only tests which are ordered with discrimination, performed with skill, and interpreted with understanding yield significant data. Accordingly, he directs this book and the companion volumes to medical students both in clinical pathology and in the transition to clinical medicine; to clinicians who must appreciate the value and limitations of laboratory data in ordering tests; to pathologists for reference and teaching; and to medical technologists, in whose integrity and skill physicians and patients place their trust.

Following the general introduction in Chapter 1, each chapter represents a convenient unit. The morphology of blood cells is discussed and illustrated in Chapter 2. The value and limitations of bone marrow biopsy are discussed in Chapter 3, and the morphology of blood cells is further illustrated by typical cases. Chapter 4 covers the peripheral blood as a whole, followed by individual chapters devoted to erythropoiesis, the structure and function of the erythrocyte, and blood transfusions. Iron-deficiency and macrocytic anemias are considered in Chapter 8 and the pathogenesis and diagnosis of hemolytic anemia in Chapter 9. In Chapter 10 a unified concept of aplastic anemia, polycythemia, and the myeloproliferative syndromes is given to which the discussion of leukopoiesis and diseases of leukopoiesis in Chapter 11 is closely related. Chapter 12 discusses the disorders of hemostasis. The methods outlined in the appendix are meant to provide a ready source of methodology parallel to the discussion in the text, not to replace the standard works which deal primarily with laboratory technic.

Dr. Miale is Professor of Pathology at the University of Miami School of Medicine and Director of Clinical Pathology at Jackson Memorial Hospital in Miami. He describes the function of this book as not only to catalog but also to integrate the facts set forth in the 12 chapters and, of greater importance, to induce a system of thinking. In the Foreword Dr. W. A. D. Anderson, Professor and Chairman of the Department of Pathology at the University of Miami School of Medicine, commented: "Medical education, whether undergraduate or the continuing education that must be a part of the life of all good physicians, needs a solid knowledge of laboratory medicine. These volumes on Laboratory Medicine are a contribution to this objective. Although evolving as a specialty, the practice of clinical pathology is a part of the skill of every modern physician, an essential component of his art and science."

General Pathology. Based on Lectures delivered at the Sir William Dunn School of Pathology, University of Oxford. By 15 British Authorities. Edited by Sir Howard Florey, Professor of Pathology. Pp. 932. Illus. 344. Price, $16.00. Philadelphia, W. B. Saunders Company, 1958.

This new second edition of General Pathology presents a sharp, fresh look at the body's reaction to injury as it offers a highly informative exploration into the basic nature of pathologic change and degeneration. Fifteen British authorities paint a penetrating picture of

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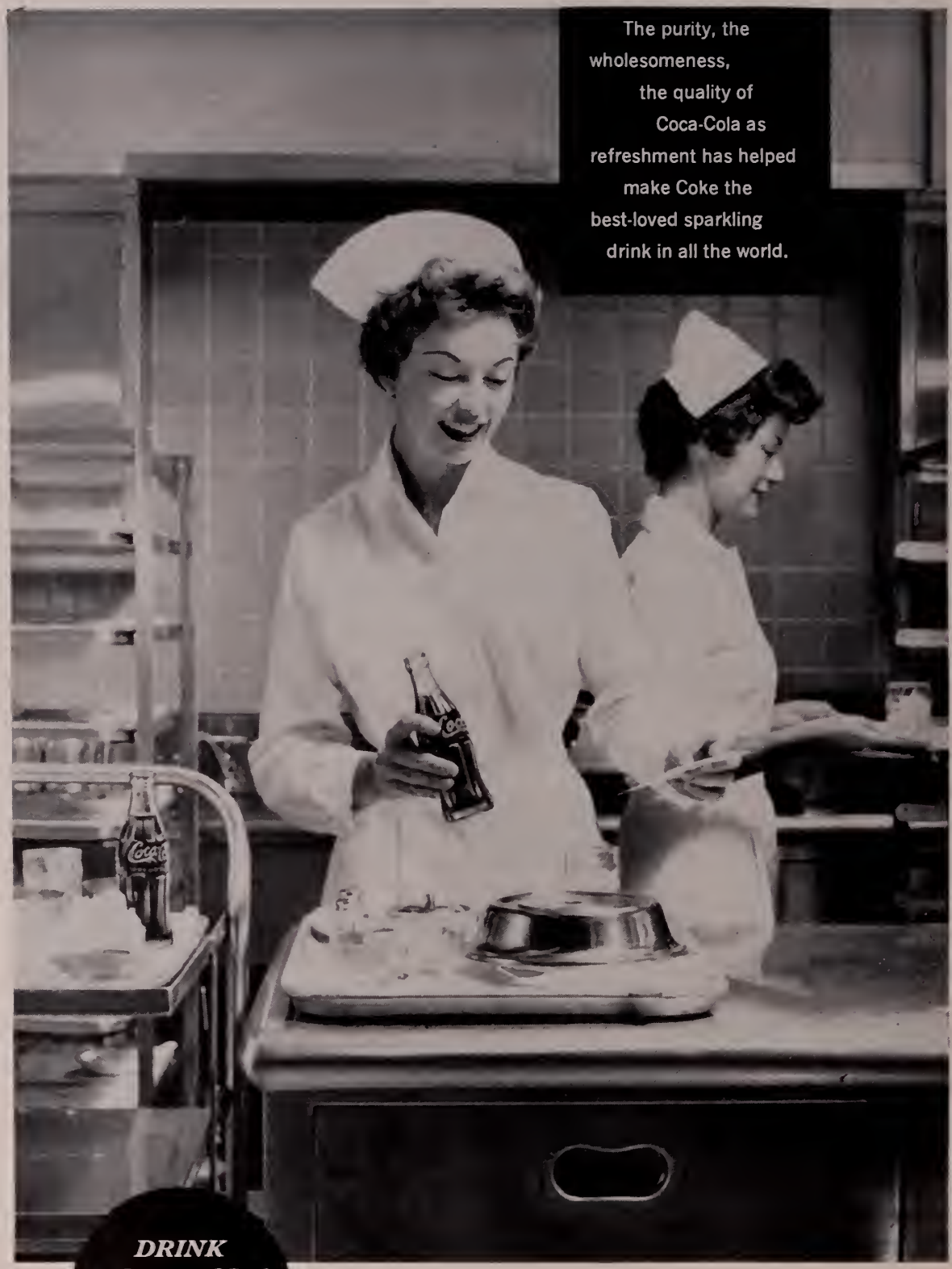
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Clinical Heart Disease. By Samuel A. Levine, M.D., F.A.C.P. Pp. 673. 216 illustrations, 914 electrocardiograms. Price, $9.50. Philadelphia, W. B. Saunders Company, 1958.

This clearcut and current appraisal of heart disease - its cause, its diagnosis and its treatment - offers easily understood advice on the practical management of a wide range of cardiac problems. The material has all been carefully chosen for the information most directly helpful in the care of the patient. Each of the common cardiac disorders is delineated in one or more full chapters, and a 200 page section on Clinical Electrocardiography includes more than 900 electrocardiograms complete with interpretation and significance. Particularly helpful are the hints and bits of advice on the various methods of examination, technic for each, which to use and what it reveals. No phase of up-to-date medical treatment has been neglected. Dr. Levine writes in such a conversational tone in this fifth edition of his book that he makes difficult problems seem less formidable. This internationally distinguished clinician and teacher is Clinical Professor of Medicine, Harvard Medical School; Physician, The Peter Bent Brigham Hospital, Boston; Consultant Cardiologist, Newton-Wellesley Hospital, and Physician, New England Baptist Hospital.

How to Write Scientific and Technical Papers. By Sam F. Trelease. Pp. 185. Price, $3.25. Baltimore, The Williams & Wilkins Company, 1958.

This manual is intended to meet the practical needs of students and research workers who are preparing illustrated papers or reports on scientific or technical subjects. It has served as a style manual for theses, dissertations, journal articles and monographs; and it has been used as a supplementary textbook in English courses. This book is the result of a process of development and adaptation. The earlier text, published under the title The Scientific Paper, has been revised and expanded, and given a title that indicates more clearly its purposes and contents. Although, in the main, the directions given are for the preparation of theses or dissertations, they apply as well to the writing of other types of technical papers and reports in the field of science, agriculture, engineering, medicine, and industrial research, and to the preparation of manuscripts of a more popular nature on scientific or technical subjects. For beginner or seasoned writer, this book offers a guide to choosing a problem and assembling initial data, discusses technic and how to develop individual style and tone and maintain them, reviews important points in grammar and helps eliminate fuzziness and inaccuracy, and shows how to handle tables and illustrations and keep this material within the practical bounds of printing mechanics.



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Ciba Foundation Colloquia on Endocrinology, Volume II. Hormones in Blood. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Millar, A.H.-W.C., A.R.I.C. Pp. 416. Illus. 74. Price, $9.00. Boston, Little, Brown and Company, 1957.

In this new Ciba Foundation symposium another important aspect of endocrinology is explored by a group of international experts. Here for the first time is a composite report on the present advances made in the study of the biological assays of hormones in blood; particularly from the pituitary, thyroid, adrenal and pancreas glands. The papers presented center mostly around two major themes: How are hormones transported in the blood? How does one measure hormone levels in the blood? Anyone who studies the physiology and chemistry of hormones will find this symposium of inestimable interest. Not only are present ideas and knowledge on the subject clarified in this volume, but avenue for future research are indicated.

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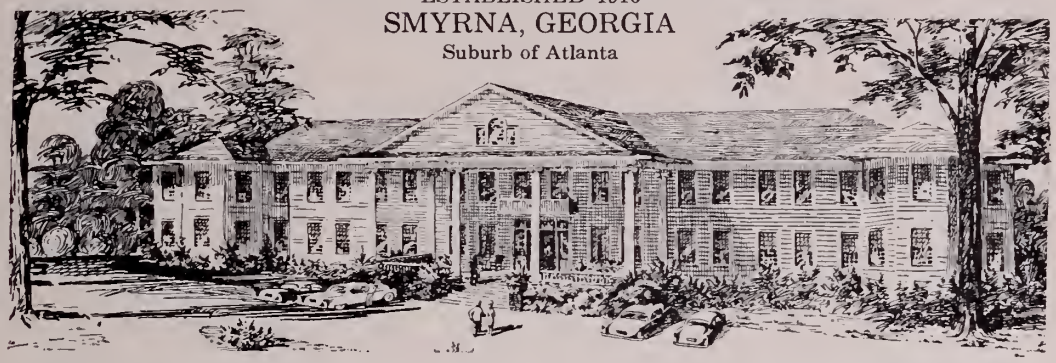
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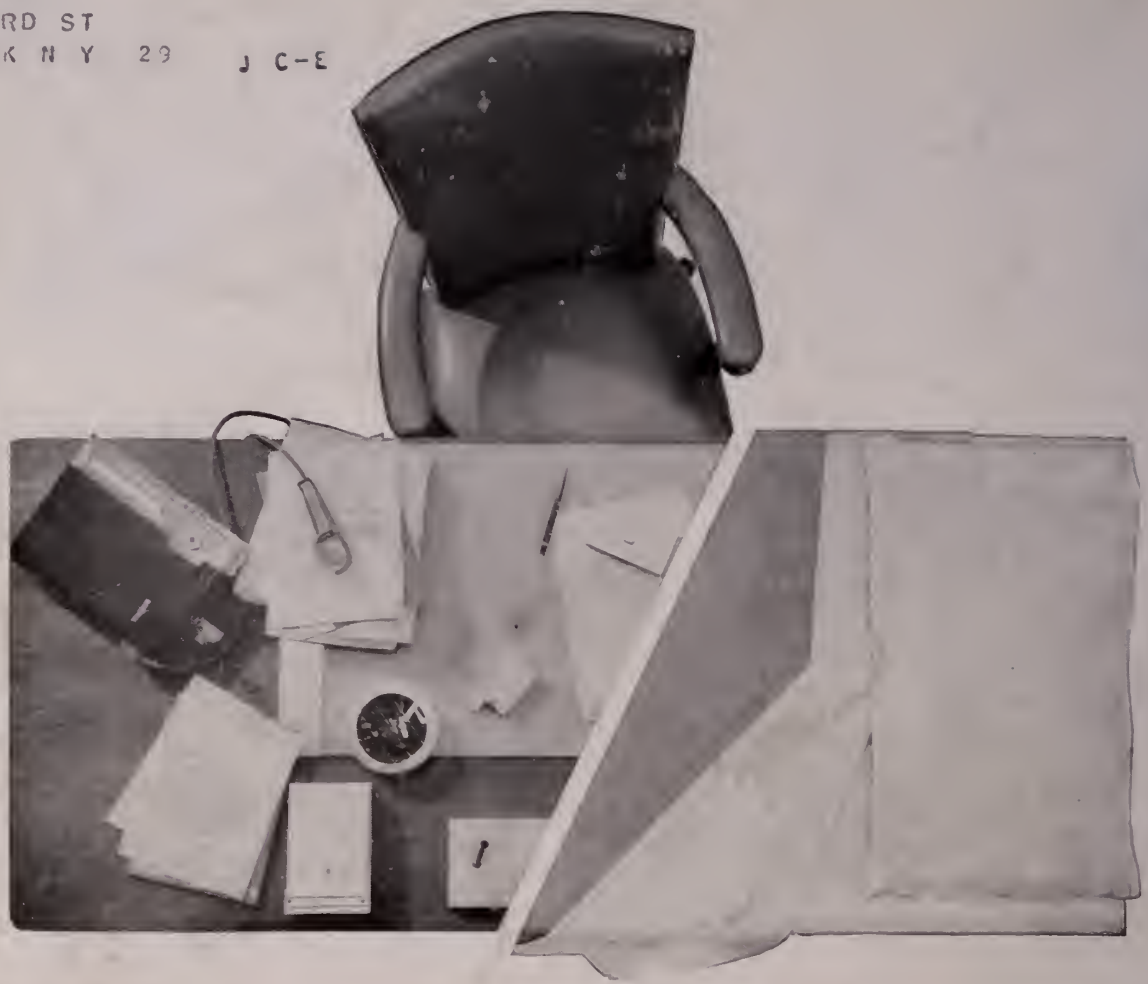
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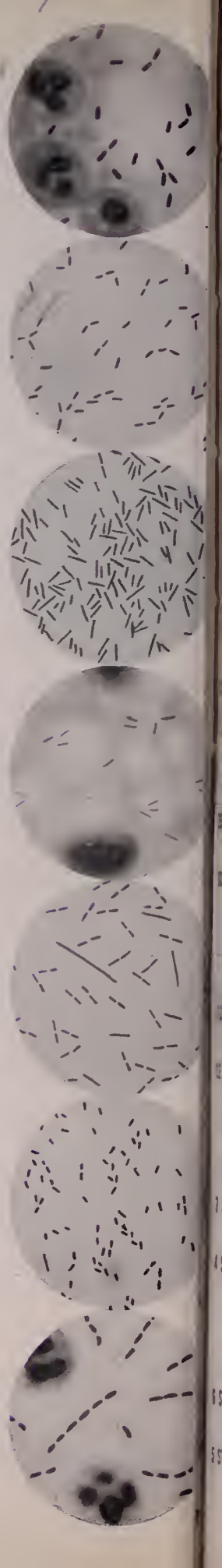
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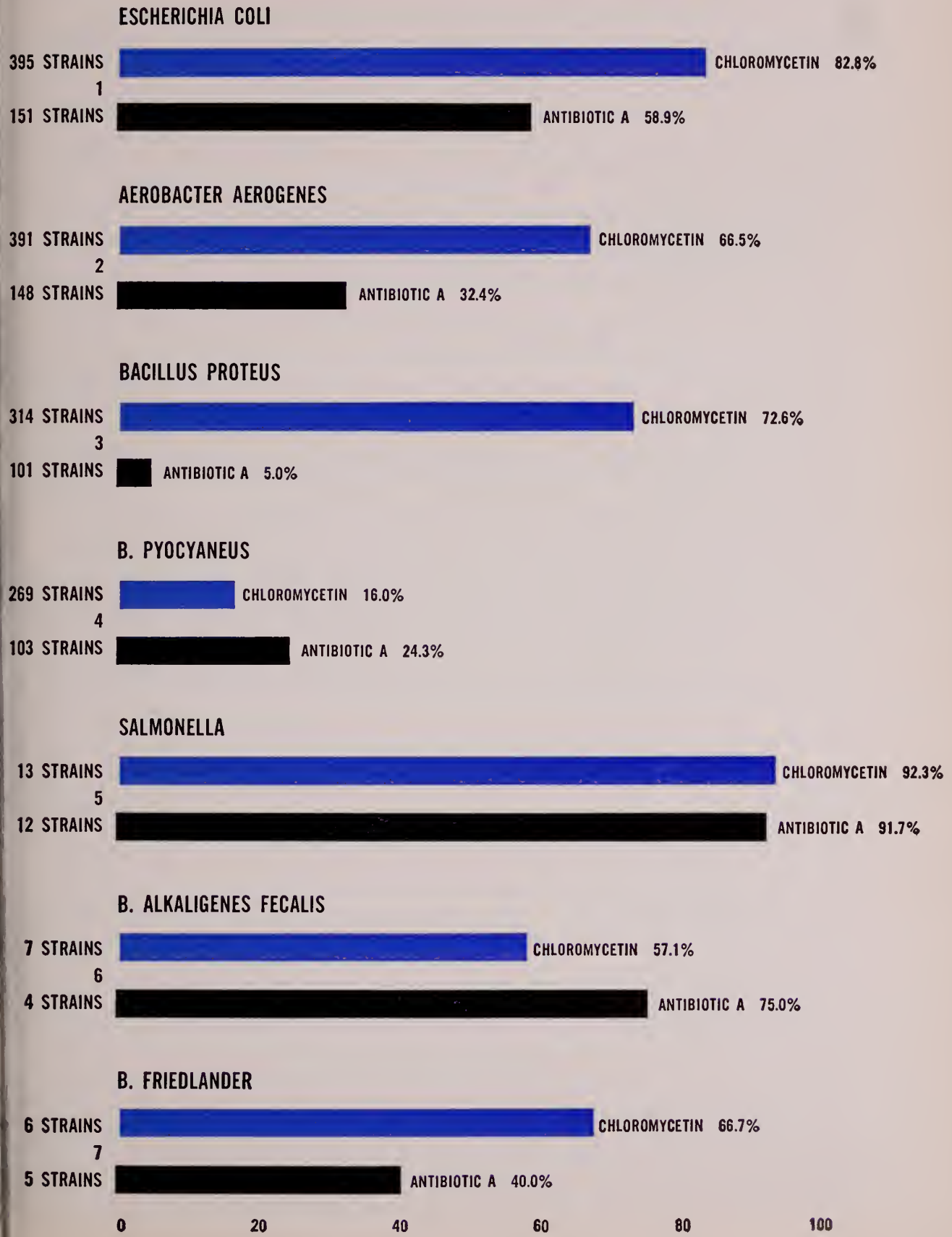
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IN VITRO SENSITIVITY OF SEVEN GRAM-NEGATIVE PATHOGENS TO CHLOROMYCETIN AND TO ANOTHER WIDELY USED ANTIBIOTIC*



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(1) Hapedorn, A. B. Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R., Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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FROM: C. K. Howe, Sales

Jim --

Here's a question a number of our detail men have tossed at me. Why doesn't Lederle's advertising for ACHROMYCIN V Tetracycline play up higher, faster blood levels the way so many of our competitors do?

As you know, new laboratory studies show pretty conclusively that ACHROMYCIN V is unexcelled in this department.

How come we haven't turned on the heat in our ads?

C. K. Howe

CKH:ls

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INTEROFFICE CORRESPONDENCE

Noted CKH

Pearl River, N. Y. 7/21/58

OFFICE DATE

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ATT'N: C. K. Howe

FROM: J. D. Roberts

Charlie --

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The fact that ACHROMYCIN V is the most widely prescribed broad-spectrum antibiotic ought to be pretty good evidence that physicians are consistently getting these results.

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J. D. Roberts

JDR:ep

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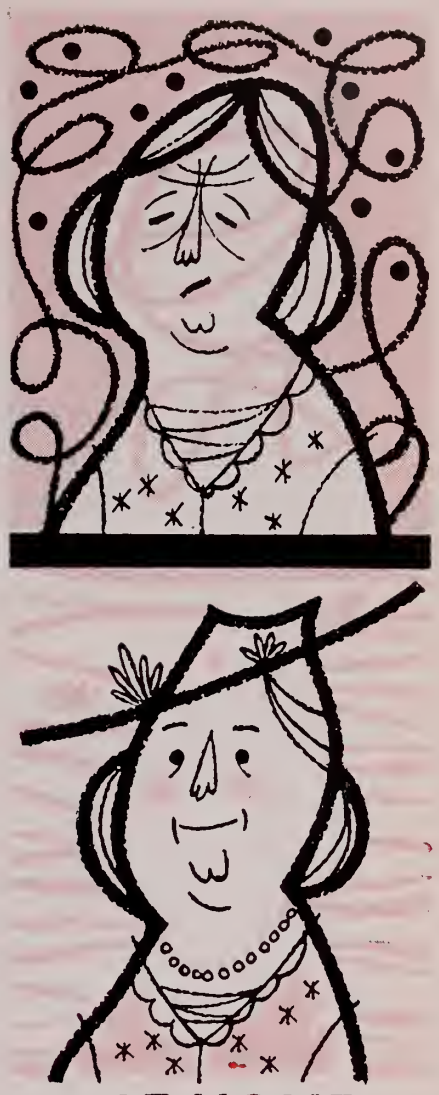
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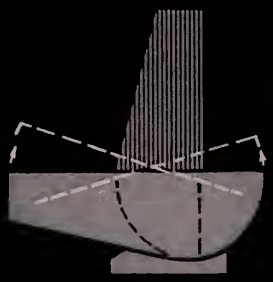
WINSTON-SALEM N. C.

1. Proctor, R. C.: Clin. Med. 6: 717 (June) 1957
2. Proctor, H. ., Bailey, W. H. and Morehouse, W. G.: J. Am. Geriatrics Soc. (April) 1958.

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WHOLE MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Whole milk	24	480	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

EVAPORATED MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Evaporated milk	11	484	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

An infant will usually take 2 to 3 ounces more than his *age in months* at 3 to 4 hour intervals to satisfy his appetite and nutritional needs. It is psychologically unwise to force prescribed amounts. Normally, the gain in weight of 6 to 8 ounces a week during the earlier months gradually diminishes to 3 to 4 ounces a week by the end of the first year. The standard one-formula mixture not only provides adequate nutrition when vitamin supplements are added; it also provides educational opportunities to prevent feeding problems.

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Is the Game Worth the Candle?

David B. Allman, M.D.
ATLANTIC CITY, N. J.

"Is the game really worth the candle?"

How many times have I been asked that question about my job as President of the American Medical Association as I make the rounds of state medical meetings throughout the country! Perhaps Dr. William Welch, A.M.A. President back in 1910, answered the question as well as anyone when he said:

"I know of no nobler work that any member can engage in than to further the interests of the Association."

Those of you who actively participate in the business and projects of the A.M.A., the Florida Medical Association and the county societies know the pleasure and the satisfaction that come from serving your colleagues, patients and communities. Nevertheless, it must be disturbing to you, as it certainly is to me, that American doctors are forced to defend this nation's competitive free enterprise system of medical practice—a system that has brought our fellow citizens the highest standards of medical care the world has ever known.

It is disquieting to hear certain medical merchandisers, particularly government, scoff at medicine's achievements, high intentions and good character. Too, it is discouraging to see these outsiders gnawing their way into the field of medicine, medical practice and the doctor-patient relationship, and actually controlling and directing the destinies of physicians and patients.

Consequently, I, too, have found myself asking the question: "Is the game really worth the candle?" Is there any percentage in fighting various outsiders who, for economic or political reasons, desire to dictate how medicine is to be practiced in the United States?

Promoting the Ideals of Freedom

Each time I ask myself these questions I am aware of the inroads made into the personal rights of doctors and patients. I am cognizant of the success of the "divide and conquer" technics used by legislators in forcing the American people to swallow compulsory national health insurance morsel by morsel.

Disheartening as the situation may be for the free enterprise system and the private practice of medicine, the medical profession and all freedom-loving Americans must not lie down and succumb to government domination or outside dictation. We in the profession recall with a good deal of pride our successful efforts to fight other legislative attempts in past years to curtail precious freedoms and to bring mediocre medicine to all and good medicine to none. We remember the great number of allies who came to our support when these groups realized the creeping effects government control of one segment of American life would have on all other segments.

The outlook for our profession and the entire free enterprise system was dark less than a decade ago, but a united effort returned this nation to sane reasoning. The situation is no less dark now, but again a concerted drive can again stop big government from managing the lives of every American.

The doctor or American who does not think the struggle for the ideals of freedom, personal responsibility, and individual initiative is necessary or worth while must be blind, deaf, or both. In medicine the freedom of choice, the freedom to use our own good judgment and the freedom from the shackles of outsiders have allowed the doctors of America to bring to the people the best medical care and the highest standards possible. Under America's private, competitive free enterprise system our people have been brought incomparable benefits, including more good living and human dignity than any system yet devised.

Yes, the game—if it can be called that—of cultivating and strengthening our democratic spirit and promoting the ideals of freedom, personal responsibility, individual initiative and faith in God is worth the candle.

President of the American Medical Association.
Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 12, 1958.

Unfortunately, too many persons—and I certainly include doctors—have the idea that freedom and democracy are anchored in our civilization. Take a look around the world and you will quickly see that they are not. Take a look at our own country and you will see that freedoms and the democratic spirit are too often denied and abused.

Yes, the world today is full of forces that wish democracy would fail. There are many others that are convinced it will fail, but thank God, there are also those who are determined that it will not fail. You and I as doctors of medicine must be members of this latter group.

I realize that it is easy to become preoccupied with our own affairs, and to surrender our responsibilities to others. Right now, let us decide that we as physicians will speak up for freedom and will act in behalf of democracy and the private competitive free enterprise system. Let us not put ourselves in the position of having to ask ourselves in years to come:

"Where was I and what was I doing when my country and my profession lost their freedom?"

Legitimate Areas of Government Concern

Government, of course, has some responsibility for the health of its citizens. In general, however, government programs should be limited to those which cannot be carried out by private resources.

I believe good health is something individuals acquire by their own efforts. It is not a right that is guaranteed by government. All we should expect as free citizens is the right of an equal opportunity of access to the means of good health. Then it is up to Americans as responsible individuals to acquire good health by our own efforts—just as we find shelter, food and clothing.

There are legitimate areas of government concern, of course—the indigent and mentally ill, for example. Even in these cases, local financing should take preference with the federal government entering only when absolutely necessary. In short, the government's purpose should be to stimulate the development of private resources and to promote a climate in which private effort and ingenuity can exert their full effect.

If our government does not follow this course, then we cannot and will not have a democratic and a free enterprise system. Instead, we will have a "we'll-do-it-for-you" government that guarantees us all the essentials of existence, including food, shelter, clothing, medical and dental care, and perhaps even an automobile. Because, however, government intrusion into medical services has been labeled "beneficent," there has been wide acceptance by legislators and the public of government's role in medical and health affairs.

Problem of Health Care for the Aged

Under the guise of social welfare, for example, proposed legislation would provide government-supervised hospitalization and nursing home care for the nation's 15 million persons eligible for Social Security benefits. Without question the proposal has rich political appeal. Without a doubt it also offers less than the best medicine.

If we follow the logic of this type of legislation to its ultimate conclusion, it portends to engulf us all in subservience to Big Government. You know as well as I do that special privileges for any class of citizens lead directly to demands by others for equal governmental treatment. What is more, why should not the government also step in and see that our aged are amply supplied with all the better things life has to offer?

The next step would be government buying through selected outlets, at prices fixed by the government, under conditions set up by a government buying commission. Such a progression is not unthinkable—it has happened, in every nation which has surrendered individual initiative and responsibility to the government.

Making our aged subservient to government with health care handouts is not the solution to this problem. The solutions lie elsewhere—and a vast movement is currently under way to attack the problem with intelligence, enlightened understanding and personal concern.

Joint Council Formed

Some of the most important and respected organizations in the health field are preparing a program which will lead toward a solution of the problem of adequate health care and better health for the aged. These organizations—the American Dental Association, American Hospital Association, American Medical Association, and American Nursing Home Association—have formed the Joint Council to Improve the Health Care of the Aged.

The Joint Council is working in three broad areas, aimed at reducing the cost of rehabilitation, providing less costly facilities for the aged who are ill, and seeking more widespread coverage of retired workers through the voluntary

health insurance industry, which in a few short years has done a phenomenal job of covering some 40 per cent of those over 65.

The Joint Council and its member groups have adopted a positive, optimistic approach to the problem. It is this approach—preventive medicine—that has helped make this a robust nation. Now the Joint Council proposes to apply all its knowledge and skills to seek improved health care for the aged; we offer the aged hope for a better life, not a crutch; we offer them a return to the mainstreams of community life and usefulness, not a one way ticket to limbo.

The Joint Council will seek methods of improving the health and health care of the aged without adding to inflationary pressures or without the expenditure of additional federal dollars.

Every advance in the health of this nation—including the phenomenal increase in longevity which lies behind the problem at hand—has come through the structure of the free enterprise system of health care. The same system, applied with new intensity and resolution to the problem of aging, is again our answer.

Basically, this problem of the health care of the aged calls for aggressive leadership of the type you people are equipped to provide, at the community level. For the good of our elders themselves, and for the good of our total national vitality, we need to help bring these millions of potentially useful citizens back to their rightful place in the family and community, to give their lives purpose and dignity.

For those who are chronically ill, we need to look into the establishment of home nursing and home care services, such as have already, in a number of communities, reduced by as much as 60 per cent the need of the community's elderly for hospitalization.

For those who are without adequate means to afford proper health care in acute illness or serious injury, we need to look into the means whereby the state and local welfare departments pay for such emergencies; in many areas, state aid to the indigent is woefully inadequate, and needlessly so.

It is voluntary community leadership that has kept this a vigorous nation. It is such leadership, now, utilizing to the full our voluntary service agencies and the proven strength of free American institutions, that will bring new hope for our aged before they are legislated into a permanent state of dependency.

Let us make another point clear right now. Everyone of our senior citizens is an extremely important individual. He or she is not just an old man or an old woman. The over 65 person is a distinct personality with hopes, dreams and aspirations just like anyone 40 years younger.

I am, therefore, opposed to any federalized system of medical care and hospitalization that would lump these individuals into a mass and reduce them to numbers and nonentities.

Uphold American Ideals

We in medicine know the need to treat patients of all ages as important individuals. We see the urgency of strengthening the democratic spirit and the private competitive free enterprise system. We realize the necessity of opposing opportunism that moves too many persons to get rather than to give, to prefer soft security to militant freedom, and to want the laxness of personal irresponsibility.

Gentlemen, I say to you that if we, and all Americans, do not follow our ideals and work diligently for them, we soon shall find Big Government sitting squarely in our laps, heavy enough to reduce you and me and every American—young and old—to manageable size.

As you therefore can see, the game is a big one, and it is indeed worth the candle.

104 St. Charles Place.

Civil Defense: Past, Present and Future

J. ROCHER CHAPPELL, M.D.
ORLANDO

"Civilization's End Is Only Thirty Minutes Away." "One Half an Hour to Annihilation." Such were the headlines recently carried by an Associated Press article after an interview with Dr. W. H. Pickering, Director of the California Institute of Technology's Jet Propulsion Laboratory, the man who designed our explorer satellites. Dr. Pickering went on to say, "In one half hour the east and west could destroy civilization. . . . How long can mankind go on living this way? . . . . Physical science has brought us to this stage. . . . The solution must come from some other source."

These headlines spread in the newspapers across the country should have sent tens of thousands of Americans anxiously searching for some means of survival, should have created a rush of volunteers into civil defense, for civil defense, or home defense, or whatever it should be called, is that other source from which survival can be planned and obtained. No such thing occurred. Mr. Average American Citizen read the newspaper headlines over his morning cup of coffee, calmly went to work, and promptly forgot about survival.

Today, Civil Defense is tremendously handicapped for lack of volunteer workers, tremendously handicapped by lack of interest of the public, tremendously handicapped by lack of funds, and tremendously handicapped by many, many other things. Civil Defense today is floundering. Civil Defense is considerably demoralized, and I do not mean this to be derogatory of any of the dedicated and conscientious men and women working in Civil Defense. Certainly we in Florida are fortunate in having Civil Defense in the capable and efficient hands of Col. H. W. Tarkington, the State Director, and Admiral C. E. Aldrich, the Deputy Director, also many county directors who are likewise devoted and energetic men. The reason for this demoralization, of course, is the sudden and unexpected advent of Sputniks I and II. Until the arrival of Sputniks I and II, Civil Defense was planning and depending on tactical evacuation as a means of survival. With the realization, however, that Russia had developed sufficient propulsive power to throw a 1,100 pound satellite into orbit and that this same propulsive power could throw a guided missile to any given target, tactical evacuation overnight became as obsolete as the Model T. Ford.

Federal Assistance

The Florida State Legislature passed the Florida Civil Defense Act on June 11, 1951, conforming in general to Public Law 1920, 81st Congress of the United States. Since Civil Defense is the law of the land by state and federal governments, let us take a quick look at what the federal government and what the State of Florida have done and are doing for Civil Defense. For the fiscal year 1952 through 1956 the federal government appropriated $60,442,666. During that time $535,125 was obligated to the State of Florida on a matching fund basis. In fiscal 1956 to 1957 the Federal Civil Defense Administration allocated $46,000 to the State of Florida to draw up preliminary operational survival plans. Dr. Lorenzo L. Parks of the Florida State Board of Health and I drew up the medical annex to those plans. The completed plans were sent to the Federal Civil Defense Administration, where they were approved, and the Federal Civil Defense Administration allocated $93,000 to put these plans into an operational status. Under the direction of Col. Gregory Freeman and his staff these plans are now being put into an operational state.

The Federal Civil Defense Administration is also prepositioning 200 bed emergency mobile hospitals, which cost the federal government about $26,000 apiece. Each county or regional Civil Defense Unit in this state may request through the State Civil Defense Office as many of these hospitals as operational survival plans indicate are needed in the community, at no expense to the local government. At the latest count we had, of these 200 bed emergency mobile hospitals in this state, one for training purposes; 13 have been prepositioned, and four have been requested and are pending approval. It is my considered opinion we should have at least 60 in this state. These 200 bed emergency hospitals are quite an engineering feat in that they carry their own water

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Chairman of the Committee on Civil Defense and Disaster of the Florida Medical Association and Deputy State Medical Director for Casualty Services.

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 11, 1958.

and light plants, operating rooms, x-ray machines, and laboratories, and can be mounted on a 2,000 cubic foot truck trailer. There are also available neurosurgical, orthopedic, and genitourinary units which can be attached to these hospitals. They can be opened only in case of disaster.

Federal Civil Defense is now in the process of prepositioning 124 radiation detection units in 124 Florida high schools. These are supplied at no cost to the schools and are for the purpose of teaching high school students how to use radiation detection instruments and, of course, the dangers of radioactive contamination. This will assure a large supply of people for use as monitors in case of a radioactive disaster.

State Aid

Let us take a look at what the State of Florida has done in preparing for a national disaster such as thermonuclear warfare. The money made available by the State of Florida during the past eight years for Civil Defense and Disaster preparedness amounts to $387,825 of which approximately one third was diverted from other state agencies. At the last two sessions of the legislature the State Civil Defense Office was allocated $37,500 per year. This was hardly enough to keep the office functioning and left practically no funds to purchase needed equipment and supplies. As of today the State Civil Defense Office owns a total of 99 radiation detection instruments, costing approximately $1,350 and does not have any funds with which to purchase more. The State of California, a few years ago, spent $3,000,000 for radiation detection instruments alone. The last Florida legislature in 1957, although it had the reputation of being the most generous legislature Florida has ever known and I have been told it appropriated more money than any other Florida legislature ever has, steadfastly refused to increase the appropriation to Civil Defense above the $37,500 per year it has received for the past four years. Yet, this same legislature appropriated one half a million dollars to build a monument to a man who wrote a song about a river in Florida but never once saw the river and never once put a foot in the State of Florida.

I cannot let this opportunity pass without paying tribute to those counties in this state which have been most generous to their local county civil defense councils. They are: Dade, Duval, Palm Beach, Hillsborough, Pinellas, Escambia, and last, but not least, my own county of Orange. The county commissioners of these counties have been most generous, not only financewise but by giving advice and aid when requested by their local Civil Defense Units.

Target Areas

Federal Civil Defense Administrator, Governor Hoegh, said recently, "The attacker will not necessarily be the winner of the next war. The winner will be the nation where the people are able to survive. The very survival of America will depend largely on the Civil Defense program." If a sufficient number of people survive to keep the wheels of industry and commerce turning, this nation will survive; otherwise, this nation will cease to exist.

Some two years ago the Central Intelligence Agency of the United States picked approximately 120 target areas in the United States. Since then some have been removed from and others added to the list, but there exist today about 120 critical target areas which our intelligence agents say will probably be selected for attack by an enemy.

Six of these are located in Florida. They are: first, the Pensacola area containing the Pensacola Naval Air Station, Eglin Field, and Tyndall Field; second, the Tallahassee area, seat of the state government; third, the Jacksonville area containing the Jacksonville Navy Base and the Naval Air Station; fourth, the Tampa-St. Petersburg area, home of McDill Field, a strategic air command base; fifth, the Orlando area containing the Pine Castle Air Base, a strategic air command base, the Naval Air Station in Sanford, and the missile center at Cape Canaveral; and sixth, the Miami area, of which Palm Beach containing the huge Pratt-Whitney Plant is a part, also Homestead and its strategic air command base, and the Naval Air Station at Key West.

This slide shows the critical target areas with their support counties. In case of a disaster, each one of these areas should function as a unit. Each support county should have plans now for taking care of many thousands of evacuees: for shelter, for clothing, for food, and most important of all, for good hospital and medical care for these evacuees. It is in these counties that the 200 bed emergency mobile hospitals should be prepositioned and located near their local hospitals to serve as an auxiliary hospital. If there are counties in which there are no local hospitals, then they should be located near schools which could function as hospitals. All the emergency mobile hospital needs to start functioning is a

roof. Simply prepositioning the hospitals in the support counties is not enough. They should be staffed with physicians from the metropolitan areas, a complete staff including all the specialties. These physicians from the metropolitan areas should be informed of their assignments in the support areas so that when the siren blows they can immediately make their way to their assigned hospitals. If all physicians in the metropolitan areas are fully informed of their duties and their evacuation assignments, it is possible that a great many more will survive than would otherwise.

I had the pleasure of hearing our distinguished guest and next speaker on this program, Dr. David B. Allman, President of the American Medical Association, when he addressed the Medical Civil Defense Conference in New York on June 1, 1957. In that address, Dr. Allman said, "It seems to me that every county in this country should be organized, should have a medical disaster committee, or whatever you want to call it, because it is only at the grass roots level, at the county level, that we can organize these things for immediate action and for good results. You can't just have it on paper on a nationwide basis or on a statewide basis. You have got to get down to where the doctors and nurses are so that you can properly organize them in teams by name and have them ready so that when and if anything strikes, we will be set to go and, as I say, it must be going to the grass roots level in order to function properly." The county civil defense committee is the last link in the civil defense chain and can certainly be considered the grass roots level. I heartily agree with Dr. Allman: These units should be competently organized; they should be equipped with emergency hospitals; and they should have medical staffs from the metropolitan areas assigned to assist them to save lives and to keep the remaining survivors of this country healthy so that the economy and industry of this nation will continue, thereby enabling our government to win a major war.

Bombs and Missiles

Just a few words about bombs and missiles: Hiroshima and Nagasaki were hit with 20 kiloton atom bombs, a force which was infinitesimal compared to a 20 megaton hydrogen bomb. A 20 megaton hydrogen bomb carries more destructive power than all the bombs dropped by all belligerents during World War II. We have built and detonated hydrogen bombs; we know Russia has also. We have plans for building still larger bombs; we feel sure our enemies have. Where will it end? Twenty megatons? Forty megatons? Sixty megatons? And on and on. When Russia put Sputnik II, a 1,120 pound satellite into orbit, we knew she had the propulsive power to throw a guided missile with a hydrogen warhead to any target in the world and with a margin of error very, very small. If Russia should decide to reduce this country to a piece of real estate and send hydrogen megaton bombs on guided missiles to as many as 60 per cent of our 120 target areas, or, a total of 2,500 megatons, to this country, our casualties would be tremendous.

The statistics in this casualty chart have been authorized by the Federal Civil Defense Administration, the Florida Civil Defense Council, and the American Medical Association. The white area of the circle represents the survivors, the red those killed instantly, and the blue areas those injured and incapacitated for from many days to many months and some permanently. The population of the United States is approximately 170 million people; of these, it is estimated 35 million would be killed instantly, another 35 million seriously injured, leaving a surviving population of approximately 100 million people. The number of physicians in the United States today able to practice medicine is approximately 215,000: of that number, it is estimated 64,500 would be killed instantly and another 64,500 seriously injured and incapacitated, leaving approximately 86,000 physicians to keep healthy the surviving 100 million Americans. Can they do it? You will note the percentage of surviving civilians is larger than the percentage of surviving physicians. This is because a greater number of physicians live in the metropolitan areas.

The great question which is causing much concern among Federal Civil Defense Administration officials and also among our top government officials is, "Can 86,000 physicians keep healthy and able to work 100 million surviving Americans?" We must remember most of these survivors will be evacuees and refugees and the incidence of disease among displaced people is tremendously increased. If we cannot keep these people healthy and able to stay on the job and build guns, planes, ships, and other needed equipment, this nation cannot survive.

Future Civil Defense

I told you in the beginning of this paper that tactical evacuation was as obsolete as a Model T Ford. I do not think anyone will dispute that,

but Civil Defense in the future will always have strategic evacuation. In case of worsening world situations, such as the Suez Canal Crisis, and other brink-of-war crises, the President can and will order strategic evacuation of nonessential individuals and equipment from the critical target areas to the support areas. It is hoped a great many physicians can be included in this group. There will always be evacuation of areas where a heavy, or lethal, radioactive fall-out is predicted.

Civil Defense for the future is also thinking of shelters, shelters in the target areas and shelters in the support areas. Its officials are hoping it will be possible to have a shelter within 15 minutes' walking distance of every individual in this country. Let me, however, point out two of the strongest arguments against shelters: first, the cost is practically prohibitive; and second, where will the size of the hydrogen bomb end? If we build shelters in the next two or three years to withstand 20 megaton bombs and then continue to build 40, 60, or 80 megaton bombs, and our adversaries do the same, shelters will be practically useless except for radioactive fall-out. I am told by a good authoritative source that we are working on and hope to have perfected soon an antimissile missile. I cannot make any further comments on that.

In conclusion, let me ask, are we and our professional allies, dentists, nurses, veterinarians, and others, organized and ready for all-out thermonuclear warfare? If not, and it is my opinion we are not, then let us get ready. Let us see to it that our support areas are fully organized and in a state of operational readiness. Let us see to it that each support county in this state has a 200 bed emergency hospital. Let us see to it that physicians from the target areas are assigned to those hospitals. Unless we are organized and ready to go when the bell rings, this land of Lincoln's Government of the People, By the People, and For the People may cease to exist as a free nation.

South Orange Avenue at Sturtevant.

Medical Economics

Sincere study by our Medical Economics Committee is not only desirable but necessary. We belong to the general economy of the nation. We must revise our policy to meet the new economic order. Then the Committee must issue a report for public consumption. Patients will be less critical if they understand the demands placed upon physicians. Things that are now considered routine in diagnosis or treatment were exceptional or unheard of fifty years ago. A doctor could be justifiably criticized if he did not use usual modern aids, but they all cost money to purchase and use.

The Public Relations Committee and the Medical Economics Committee must work closely together. In fact, the latter may be considered more of a study group whose conclusions can be presented by the former.—*Picomeso Mail Bag, Pinellas C.M.S.*

Corrective Surgery of the Nasal Framework

With Emphasis Upon Septal Surgery

RICHARD T. FARRIOR, M.D.
TAMPA

In discussing surgery of the nasal framework it is the intention to emphasize modified technics in surgery of the nasal septum and to mention rhinoplasty procedures only when there is a relationship to septal surgery. It is not my intention, then, to give the details of rhinoplastic surgery, which has been reviewed many times before. Some of the modified technics which include plastic surgery principles are simple and would be easy to add to one's present methods in septal surgery whether or not one has had rhinoplastic training.

Although the details of rhinoplastic surgery will be omitted, as will be emphasized, it is frequently difficult to separate the two surgical procedures if one is to analyze correctly and repair particular nasal deformities to restore normal function.

If physiologic indications for nasal surgery are to be followed, it is necessary to have a basic understanding of and to correlate accurately structure and nasal function. It necessarily follows that there would be a need for modification of older surgical technics. The so-called "routine SMR" improperly used gave a bad name to septal surgery in the past, both for the public and many physicians. Because of some unsatisfactory results as well as complications of this operation, many rhinologists abandoned the procedure entirely. The so-called Killian submucous resection with proper indications continues to be a worth while operation and certainly should not be discarded. During the past 10 years in particular, there has been re-emphasis of the influence of structure upon nasal function, particularly by Proetz, Fomon, Cottle, and others. The production of eddy currents and drying of the mucous membrane with its deleterious effect upon ciliary action is fundamental in nasal physiology. That external deformities of the nose, apart from septal deviations, influence air currents has been well proved by careful laboratory and clinical experiments. Again, correction of external deformities is often necessary to restore normal comfortable breathing. I prefer and advise correction of external and internal deformities as a combined single operation.

The importance of the anatomic baffles about the anterior nares has been emphasized by Cottle and Fomon. This area is the narrowest point in the air passages, and therefore changes of only a few millimeters in the cross-sectioning of the opening alters the resistance markedly.

With narrowing in this area either by collapsed alae or septal deflection there is increased resistance, and respiration is forced. A normal degree of tubular resistance results in the proper excursion of the thoracic cage and more efficient filling of the lungs. Perhaps more important, the patient has a sensation of more comfortable breathing.

Etiology

1. Trauma
2. Combination of trauma and growth
3. Influences of growth alone
4. Developmental
   - (a) Septal deflections present at birth
   - (b) Septal deflections associated with other congenital anomalies, cleft palate, harelip, et cetera

Injury certainly plays a large part in the production of septal deformities, whether there is an immediate dislocation produced following the injury or there is accentuation of an earlier minor deviation as growth occurs. Even without injury many believe that the progressive forebrow which produces cranial advancement over the somewhat retrogressive nose produces buckling of the septum in later life. With continued growth of the septal cartilage and the vomer, the dorsum of the nose is raised, producing the adult changes in the profile.

The very location of the septum in the midline and its relationship to the lateral maxillary processes leave it in a position for the production of some asymmetry. Sections of the human embryo show the relationship with cleft palate deformities. Proetz described the influence of the high narrow palate in the production of septal deflections. Goldman described the maxillofacial triad in which there is an associated dorsal nasal hump,

Read before the Florida Society of Ophthalmology and Otolaryngology, Hollywood, May 5, 1957.

receding chin, high narrow palate, and malocclusion of the teeth (fig. 1).



Figure 1

Anatomy

In order better to understand the components of a particular septal and combined external nasal deformity, it is well sometimes to review in detail the structures contributing to the septum apart from the major quadrilateral septal cartilage, vomer, and perpendicular plate of the ethmoid. I should like to emphasize other components of the septum which in particular deformities may be important. Even the small vestigial cartilage of Jacobson's organ at the junction of the vomer and maxillary crest contributes to the formation of basal septal spurs. The anterior nasal spine and the maxillary and palatine crest are frequently involved in deviations and spur formations. Deviations of the nasal tip and abnormalities of the columella necessarily include the medial crura of the lower lateral cartilages, the membranous septum, and the anterior nasal spine. Even the lesser apparent septal crest of the nasal bone and the sphenoid rostrum in particular instances may be important. The intimate association of the septum with the upper lateral cartilages and nasal bones and interrelationships with the columella make it difficult to dissociate the septum and external deviations.



Figure 2

Analysis of Deformities

Particular analysis of the individual deformity must be made if proper surgical procedures are to be carried out. Is the obstruction of the anterior or posterior type; is it high or low; are dislocation and lamination present, or is there reduplication of the cartilage; are there basal spurs; is

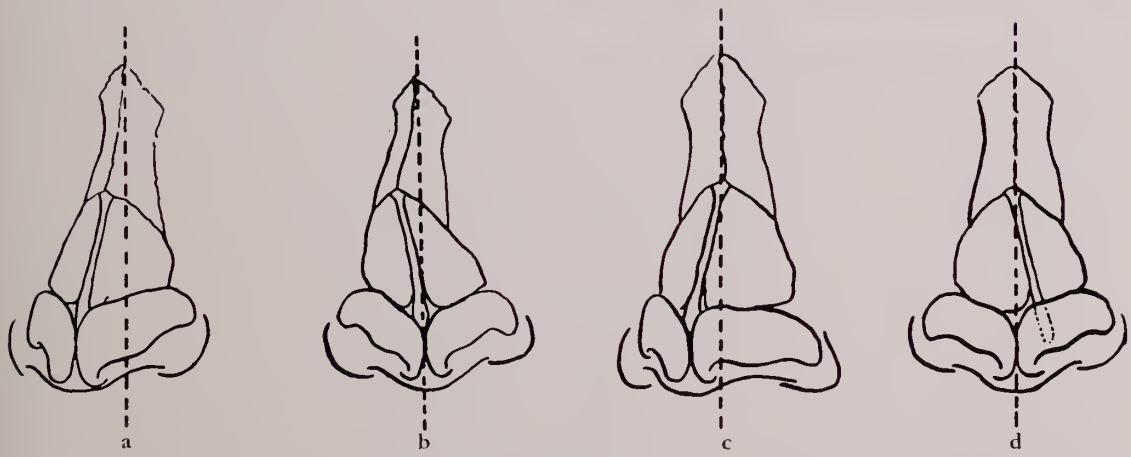


Figure 3



Figure 4

there an associated external deformity which is also contributing to the nasal obstruction?

What components of the external vault are involved? Is the entire nose, including the tip and nasal septum, deviated with associated hypertrophy of the upper lateral cartilage on one side, or is only the midportion of the dorsum and septum deviated with return of the tip to the midline (figs. 3a and b)? Is there deviation only of the cartilaginous dorsum involving the tip and septum, or is the septum only deviated with dislocation into one nostril along the caudal margin (figs. 3 a, b, c, d)?

A case with anterior dislocation, a transverse septum, and reduplication of cartilage is shown in figure 2. Certainly such a case requires more than a simple submucous resection.

The patient shown in figure 4a and b presents no remarkable profile. From the front, however, the lateral vault is seen to be depressed: there is deviation of both the cartilaginous and bony dorsum to one side. In this patient not only would attempts to hold the septum midline be unsuccessful, but septal surgery without associated external surgery would not improve his breathing. With or without a deflected septum, the depressed lateral vault alters breathing, especially on the involved side. This patient required osteotomies without change in the profile.

In the saddle nose, is the deformity due simply to loss of septal support, or is there involvement of the entire dorsum, bony and cartilaginous? In the case of pronounced saddling shown in figure 5a and b, there was also scarring over the dorsum due to lacerations received during one of the patient's several injuries. In the saddle deformity with columellar retraction, shown in figure 5c, there is an apparent hump with loss of septal support beneath the tip of the nasal bones. The nasal tip is depressed.

The patient shown in figure 5e lost septal support along the dorsum as a result of fractures sustained in an automobile accident.

Another deformity which must be analyzed in relation to the septum is the harelip nose (fig. 6a). With such a deformity there is almost invariably an associated septal deviation. The deviation most commonly involves both the bony and cartilaginous components of the septum. A review of the six week human embryo will recall the relation of harelips to the external nose. Are there then the associated deformities with underdevelopment of the maxilla on the involved side in the unilateral harelip nose, posterior or dorsal displacement of the lower lateral cartilage, flattening of the nasolabial angle and displacement of the medial crus with the resulting distortion of the nostril? One must further determine whether or not the tip is deviated or only apparently deviated. What is the relation of the lateral alar attachment with the columella and the alar attachment of the uninvolved side?

Opposite

Figure 5


a
b
c
d
e
f

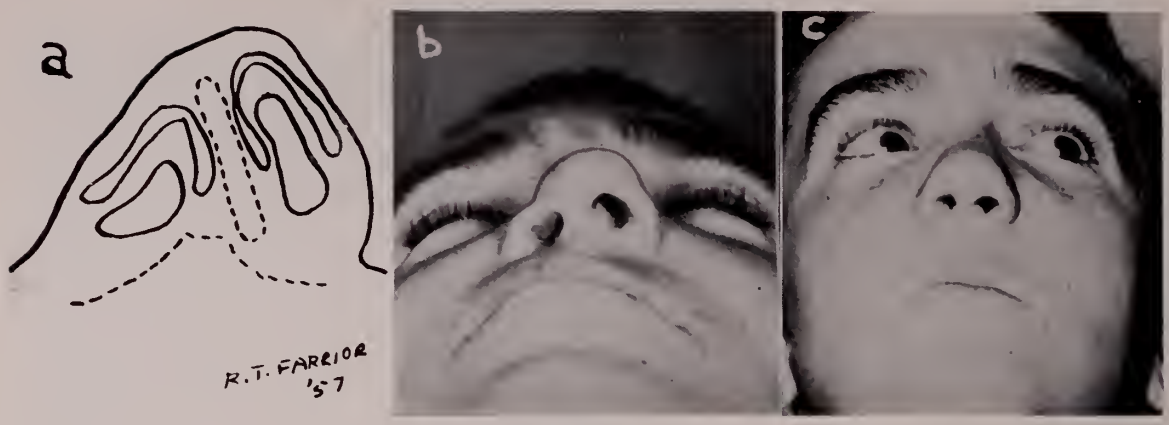


Figure 6

Surgical Technic

Historical Background

The origin of the present day technics in septal surgery dates to the late nineteenth century and beginning of this century. During the early days many of the grand old names of otolaryngology were associated with the submucous resection operation. Ingals, in 1882, suggested the submucous removal of a portion of the septal cartilage. Names familiar to all—Freer, Killian, Hajek, Ballenger, Yankauer, Sir St. Clair Thomson —added refinements and modifications to the surgical technic. Joseph, in Germany, at the same time was developing many of the technics of the rhinoplasty and contributed greatly to present day management of septal as well as external nasal deformities. The emphasis previously mentioned concerning the influence of structure upon nasal function led to many improvements and refinements in methods and fostered what I believe is more important, the thinking of the rhinologist and the rhinoplastic surgeon in terms of nasal physiology and physiologic indications for surgery.

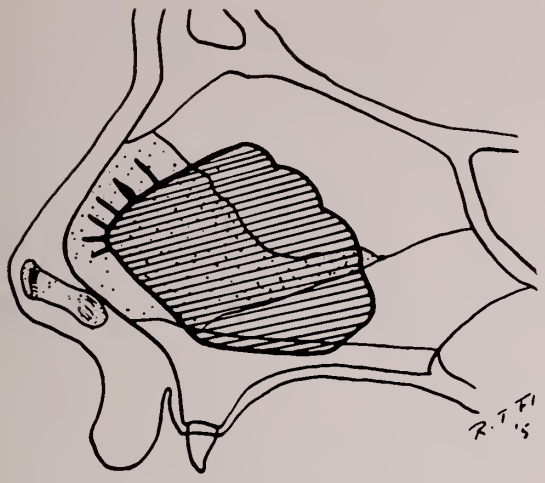
Submucous Resection

In essence, Killian's operation with modifications leaves ample support along the dorsum and caudal margin of the septum (fig. 7). There is adequate if not radical removal of posterior septal deflections in this operation. When indications are present, this operation as such remains usable. Minor external deviations of the cartilaginous vault and higher septal deflections can be corrected by the addition of cross-cutting as I have illustrated. One or more strips of cartilage may be removed to help break the resilient spring. In dislocations of the caudal margin, high anterior deflections and deviations associated with external nasal deformities, this operation does not correct the deformity.

In performing this operation, my own methods are standard. I will offer a few comments or hints which I think are helpful. I continue to infiltrate with a local anesthetic and epinepherine beneath the mucoperichondrium and mucoperiosteum not only for anesthesia, but because I believe this procedure aids elevation and certainly is helpful in hemostasis. It is possible to make in one move the incision through the mucoperichondrium and cartilage on one side but not through the mucoperichondrium of the opposite side. This saves a second step and one motion. Only the deflected septum is removed. The straight sections of removed cartilage, or sections which can be straightened, are replaced with the thought that contracture or the occurrence of too flaccid a partition can be prevented. All rents in the mucous membrane are repaired with fine chromic catgut on a plastic needle or fine suture carrier. Rents opposite each other are separated by a cartilage insert. Careful elevation and prevention of rents are, of course, the most desirable, but they sometimes happen, and it is desirable to have a course to follow. The incision is closed with one or two fine chromic catgut sutures allowing room for drainage, but preventing retraction of the elevated mucous membrane posteriorly with healing, or possible forceful separation during the process of packing the nose.

In dressing the nose I have used everything suggested, I believe: plain Vaseline gauze, Vaseline gauze and dental wax splints, combination

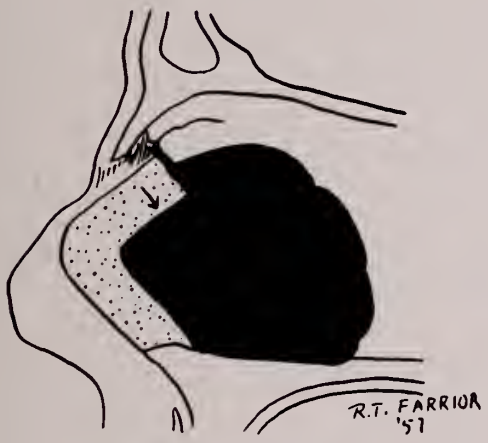
Opposite
Figure 7



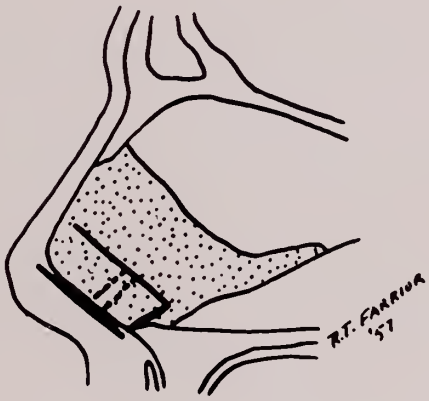
a.



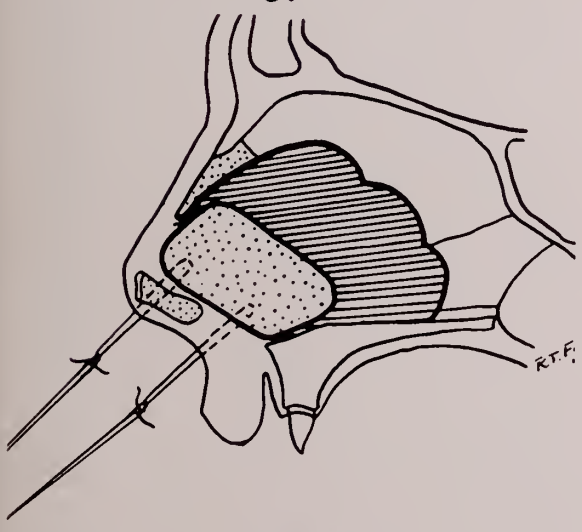
b.



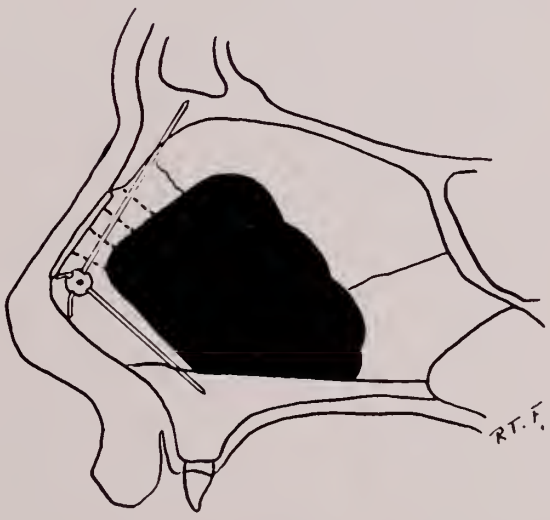
c.



d.



e.



f.

of polyethylene tubing and Vaseline, Vaseline inserted within a rubber sleeve, et cetera. Presently, I am using synthetic cellulose sponge. This sponge is formed about a cotton cord core which helps hold it together. There is a desirable amount of swelling when moist for pressure. The most outstanding feature is the ease with which this material is removed and the minimal amount of bleeding associated with its removal. Tissue reaction about the substance seems to be minimal. It lacks some of the molding qualities of petrolatum gauze, but single or smaller strips can be devised to pack more narrow areas. Polyethylene tubing along the floor of the nose with Vaseline packing above has some advantage in allowing breathing and preventing uncomfortable negative pressure. The polyethylene tubing alone allows too much swelling above the tube which produces increased fibrosis, and in rhinoplasty where the intercartilaginous incision has been made, this leads to some anterior stenosis or webbing.

Combined Submucous Resection and Rhinoplasty

When the septal deformity is not contributing to or associated with the external deformity, the routine submucous resection may be performed. In such cases, I much prefer to remove the dorsal hump and shorten the nose prior to performing the septal operation. In this way one knows exactly how much dorsal and columellar support is being left and whether or not the external deformity is truly a separate entity.

When a Killian type submucous resection is performed, one can make his approach through the transfixion incision along the caudal margin of the septum, or make a separate incision approximately 1 cm. posterior to the transfixion incision (fig. 7b). I have used both methods, but frankly prefer to make the separate incision, which leaves good columellar support with attached mucoperichondrium for nutrition, retention of the strut in position, and the prevention of contraction. I do not believe that the separate incision contributes significantly to additional scar formation.

Patients requiring a submucous resection can have this surgery performed prior to the rhinoplastic surgery by the rhinologist not trained in plastic technics; however, the rhinologist must carefully analyze the deviation to be sure it is not involved in the external deformity and must use careful judgment in leaving adequate dorsal support so that collapse will not occur when the dorsal hump is removed. When a previous submucous resection has been performed, this puts an extra burden upon the rhinoplastic surgeon as he can never be absolutely sure ahead of time how much of the septum has been removed.

In performing the combined procedure one must be careful at the junction of the cartilage and perpendicular ethmoid just beneath the nasal bones (fig. 7c). It is at this point that support will frequently be lost with a drop of the dorsum just beneath the distal tip of the nasal bones. Fomon, I believe, has overstressed the ability of the upper lateral cartilages and attachment of these cartilages to the septum and nasal bones, to give support without septal support below.

Septal Reconstruction

Reconstruction of the septum generally implies repositioning that which is already there, or using some form of free cartilage graft. Operations of this type are necessary when there is displacement of the caudal or lower free border of the septum. This displacement may or may not involve the anterior spine or the tip of the nose. Septal reconstruction in one form or another is always indicated when there is a twisted external deformity or lateral deviation involving the entire nose.

Metzenbaum, in 1929, advised replacement of the dislocated end of the septal cartilage rather than removal of this cartilage as an improvement over the regular submucous resection (fig. 7d). His cross-cutting and attempt to break the lines of force still is usable in some deformities and surgical situations, although most agree that his technic is not quite adequate and that the cartilage tends to return to its previous position. He elevated the mucoperichondrium only on one side, made an incision through the deviating angle of the septal cartilage but not the opposite mucoperichondrium, and then replaced the cartilage to the midline. Peer, in 1939, advised removal of the caudal deviation and replacement of a cartilage strut in a columellar pocket. Fomon later added modification and variations to this technic. Harbert, in 1940, advised elevation of the mucoperichondrium on both sides of the septum and replaced the inferior margin in a groove made in the nasal spine. This technic is a forerunner of the operation Goldman recently advocated.

Goldman utilized a limited transfixion incision as used in the routine rhinoplasty. He elevated mucoperichondrium bilaterally making two in-

cisions in the cartilage roughly paralleling the caudal margin. These two strips of the cartilage which he described as pedicle grafts are replaced into the midline. They are sutured to the columella with two mattress sutures. Excess mucous membrane and the anterior nasal spine are removed when necessary. This is a most useful procedure. It involves removal of a minimal amount of tissue; the likelihood of resorption of the cartilage is minimal; and there is, as a result of these factors, little interference with growth. This last factor makes the procedure useful in children.

Concerning Goldman's pedicle graft, I should like to make one point in physiology. Cartilage receives its nutrition by imbibition of lymph primarily from the mucoperichondrium. If the mucoperichondrium is elevated bilaterally, the "pedicle grafts" in reality are little more than free grafts. The cartilage does not receive "blood supply," so to speak, from the attached pedicle as in a pedicle skin graft.

With reinsertion of a free autogenous cartilage from the patient's own septum, I have seen little resorption.

Lierle and Huffman, with whom I trained at the University of Iowa Hospital, advocated a modified type of Galloway operation (fig. 7e). In this procedure an incision is made over the free border rather than posteriorly as in the routine submucous resection. A large portion of septum may be removed, including the caudal margin and a portion beneath the dorsum. Although I strongly advocate conservative removal of septum, I have removed the septum this radically in over 100 cases. This autogenous cartilage is then refashioned and drawn into a columellar pocket with pilot sutures as a free graft. This forms then more than a strut, being utilized also to give support and resilience along the dorsum. The added support posteriorly in the septum aids in preventing the undesirable flaccid septum. As with all columellar struts, care must be taken not to make the pocket too deep or a "frozen tip" may result. In this procedure I almost uniformly remove the anterior spine and maxillary crest providing a flat surface to receive the graft, thereby avoiding subsequent dislocation.

I save all removed septal cartilage of any significant size by preserving it under refrigeration in aqueous Merthiolate diluted with normal saline. In taking the septum apart one is not always assured of an adequate piece for replacement, and preserved homogenous cartilage is usable. A gratifying percentage of the grafts remain in, and even those that resorb usually prevent the associated deformities of contracture. I have never had to remove one of these septal inserts.

If the septal deviation is high and near the nasal bones, a finding not uncommon in the twisted nose, it may be necessary to make multiple incisions perpendicular to the dorsum, thus lobster-tailing the cartilage and allowing it to be moved to the midline (fig. 7a and f). Removal of narrow strips of cartilage between these incisions as performed by Becker may be necessary to break the spring. This technic of incising the cartilage may also be useful in minor deviations of the columellar support in the routine rhinoplasty.

In the area beneath the nasal bones, as mentioned before, loss of dorsal support can occur. This is true especially if it is necessary to fracture the ethmoid bone. When loss of support is feared, or it is not possible to maintain the septum in the midline, a "septal pinning" may be carried out.

This procedure (fig. 7f), which may not be familiar, was devised by Dr. Richard E. Straith, the son of Dr. Claire L. Straith of Detroit, with whom I had my fellowship in general plastic surgery. By using a small Kirschner wire and a pistol-grip drill, the septum may be threaded beneath the dorsum and fixation established in the area of the nasion. If additional support is desired, a columella post pin can be used. This pin is fixed in the maxilla and attached to the dorsal pin with a lock nut. The septum is cross-cut beneath the dorsum to allow repositioning. To date there have been no complications even when the pin has entered the frontal sinus.

I do not use this procedure ordinarily, but it is, I believe, useful and good to have in one's armamentarium. The added support of the Kirschner wire also has its uses in nasal fractures.

Septal Reconstruction and Rhinoplasty

Septal reconstructions in combination with the rhinoplasty is quite applicable. In such cases the separate incision is not made. Elevation of the mucoperichondrium is carried out around the caudal margin of the septum through the transfixion incision. In many instances when the nose is shortened by removal of a wedge from the caudal margin of the septum, a significant portion

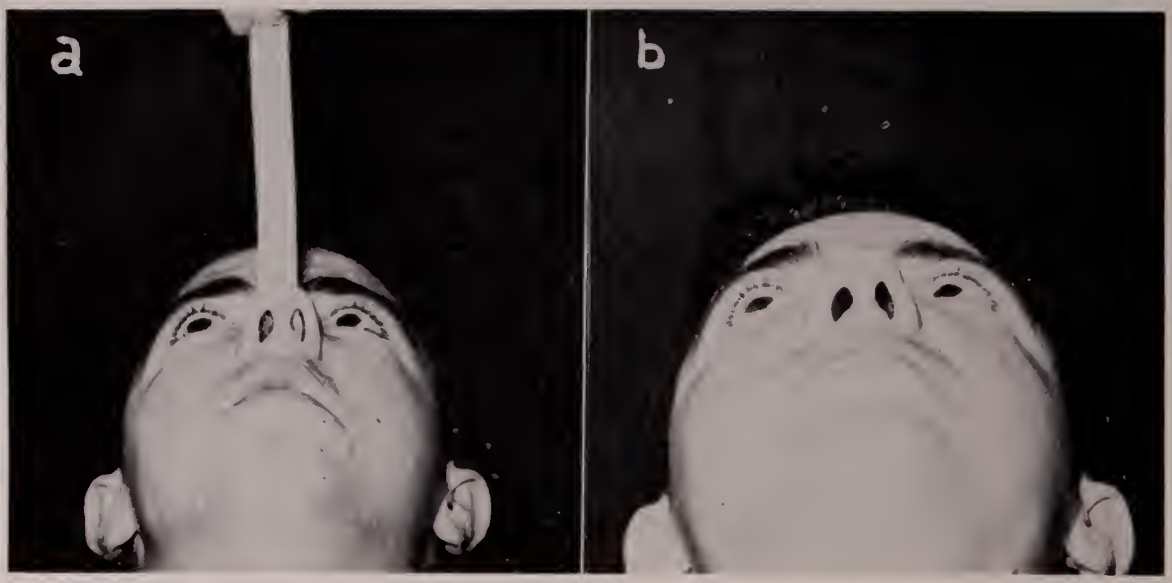


Figure 8

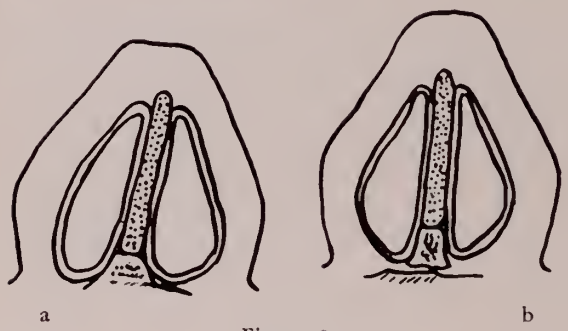


Figure 9

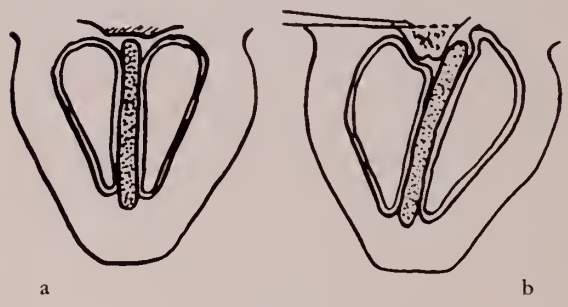


Figure 10

of the anterior dislocation is removed, simplifying the remaining correction. When the base of the wedge removes the dislocation toward the nasal tip, the remaining dislocation near the anterior spine may be elevated bilaterally, a strip removed along the base of the strut, and the strut moved to the midline.

When there is a developmental anomaly and the cartilage is not dislocated off the spine, it is advisable to leave the cartilage and bone in contact, and with the osteotome separate the nasal spine along the floor and move the entire bony and cartilaginous strut to the midline (fig. 9a and b). In this case there is no interference with the mucoperichondrial and mucoperiosteal attachment.

If there is dislocation and the anterior spine is removed, the struts frequently can be replaced in the midline without removing a section of cartilage (fig. 10a and b).

In the saddle nose, the insertion of the larger piece of autogenous cartilage as in the Galloway procedure, in addition to giving columellar support and correcting retraction in this area, helps raise the nasal dorsum, thereby increasing the size of the airway. If a dorsal graft only is used, the external defect is filled; however, nothing has been done to enlarge the airway. This is also true when only a narrow columellar strut is used (fig. 12). For this reason, I prefer where possible to use the larger piece of cartilage, providing more support along the nasal dorsum, at least in the important area of the anterior nares and vestibule, as in figure 7e. I prefer to insert all columellar struts through an incision posterior to the medial crus or the area of the transfixion incision rather than through an incision anterior to the medial crus. In the simple reconstruction with the insertion of this autogenous cartilage, it is not necessary to carry the incision through the mucoperichondrium of the opposite side. The harelip nose often requires extensive reconstruction about the base and tip in combination with septal reconstruction (fig. 6b and c).

In 283 carefully followed and photographed cases of nasal plastic and septal reconstruction procedures apart from the routine submucous re-

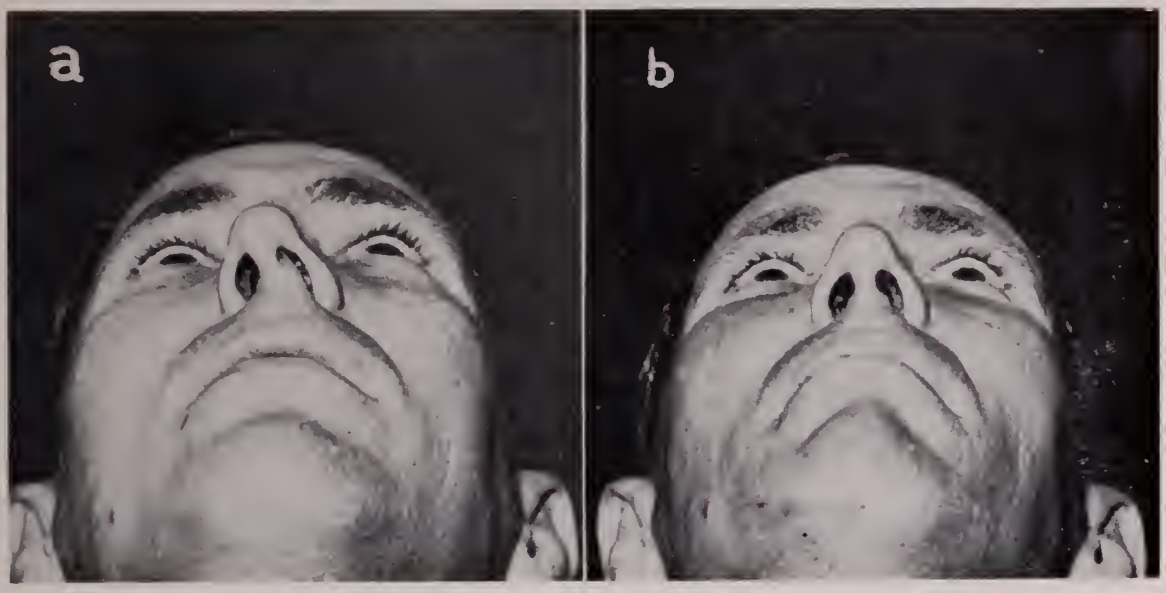


Figure 11

section operation, rhinoplasty and septal reconstruction were combined in 150. At the present time, a combined procedure is being performed in almost all of my cases requiring rhinoplasty. All too often the deviation, which seems unimportant beforehand, proves to be obstructive when the osteotomy is performed and the nose narrowed. Also, the deviations may prevent medial displacement of the lateral wall on one or both sides, distracting from the results of the rhinoplasty.

Discussion of Cases

Cases demonstrating combined septal and external nasal deformities and dislocation of the caudal margin of the septum alone requiring septal reconstruction are illustrated. Only a few cases drawn from the series presented are shown to make pertinent points relative to an analysis of deformities, correlation of structure and nasal physiology, and surgical correction of the nasal framework.

Figure 8a illustrates the typical anterior dislocation with the transverse septum requiring septal reconstruction. Autogenous septal cartilage was used as a graft placed into a columellar pocket (fig. 8b).

With the degree of deviation of the entire tip, and dislocation of the anterior spine and septum shown in figure 11a, it is apparent that lateral osteotomy and a combined procedure were necessary to return the nose to midline. This surgery was performed and the septum reconstructed by a procedure similar to that of Goldman and Becker, fig. 11b).

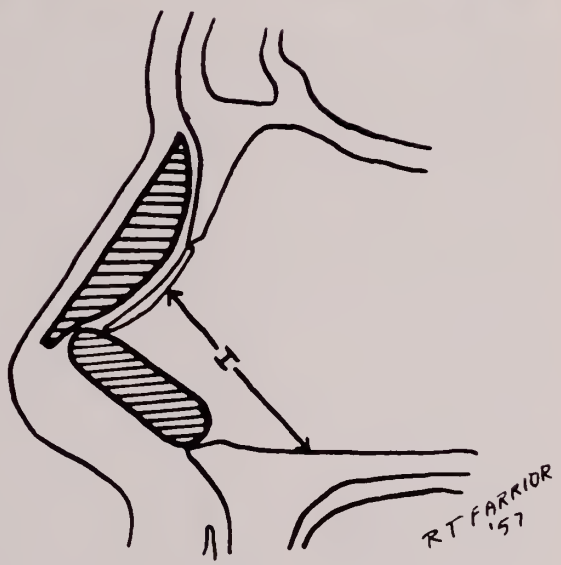


Figure 12

The external deformity shown in figure 13a was not pronounced; however, breathing was greatly impaired as can be seen from the adenoidal type facies. Septal reconstruction and rhinoplasty were combined, and figure 13b shows the resulting profile. In figure 13c, anteriorly much callus formation and depression of the lateral wall of the nose can be seen. The nose was returned to the midline and the depressed lateral vault elevated with refracturing (fig. 13d). A considerable degree of septal dislocation with reduplication is shown in figure 13e. The septum was reconstructed with an autogenous septal graft (fig. 13f).

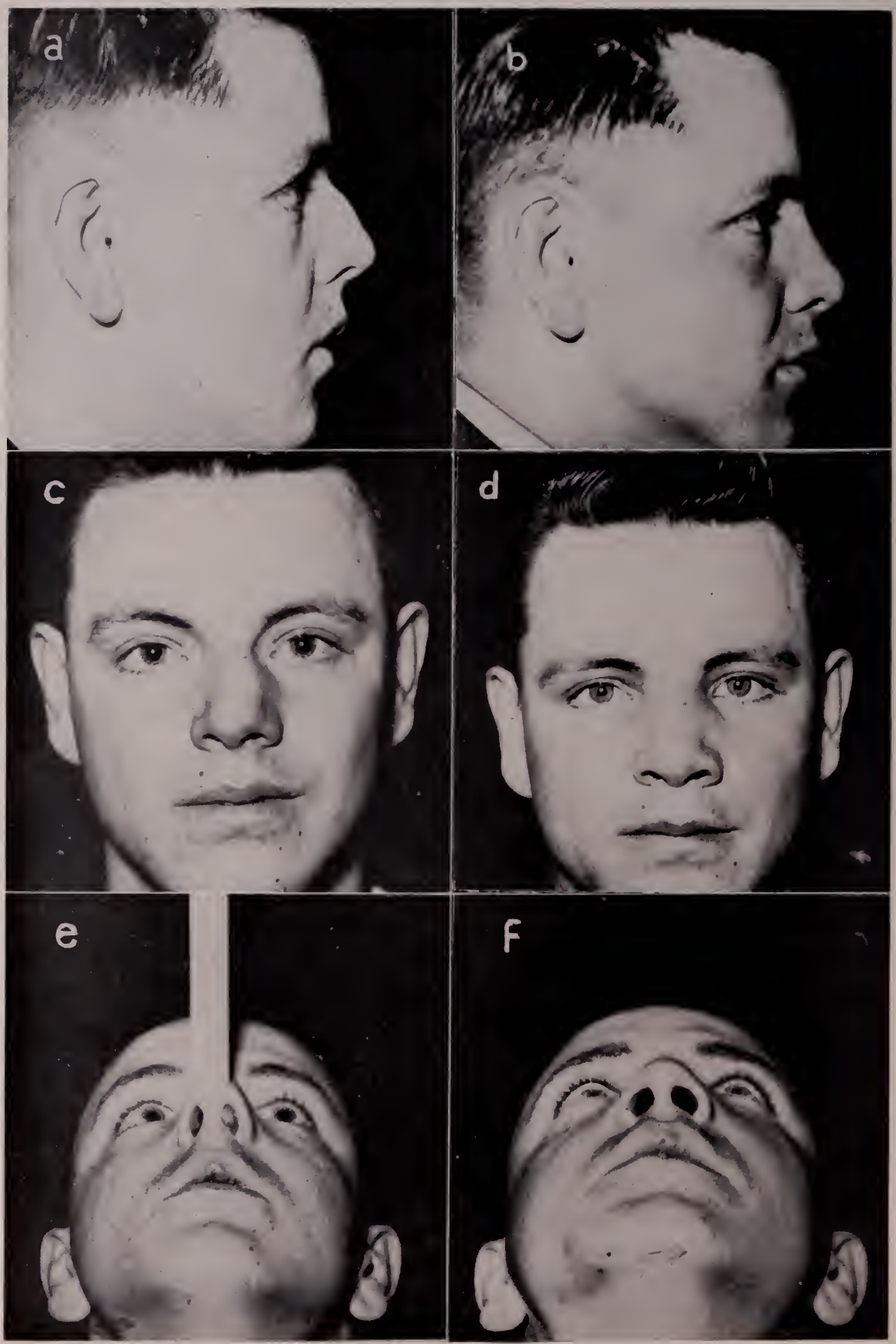

a
b
c
d
e
f



Figure 14

A combined traumatic and congenital deformity is illustrated in figure 14a. The dorsal hump is shown as well as some loss of the nasolabial angle. The patient had an unusual anterior nasal spine which extended with a keel from the base of the teeth almost to the tip of the nose. The support of the spine was not removed; however, a wedge was taken out to increase the nasolabial angle. Postoperatively, the profile was not only more pleasing, but breathing was much improved (fig. 14b).

From below, in figure 14c the deviation of the tip and septal dislocation can be seen. In figure 14d, from below the septum is shown returned to the midline.

The pronounced saddle deformity shown in figure 5a was corrected by a septal reconstruction with insertion of a rather large septal graft to elevate the dorsum internally. In addition to the septal reconstruction, an autogenous rib graft was used to build up the dorsum (fig. 5b).

In the deformity shown in figure 5c, with loss of cartilaginous support, a septal reconstruction only was performed. The postoperative result (fig. 5d) shows that support can be obtained along the dorsum without a dorsal cartilage graft. Although

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Opposite
Figure 13

the tip is perhaps not ideally elevated, the columellar retraction is lost, and breathing is greatly improved.

The patient shown in figure 5e sustained pronounced comminution of both the nasal bones and nasal septum in an automobile accident. I treated her initially as an emergency, and although I could keep the bones in position, I was unable to maintain septal support. Six months following the injury, a submucous resection was performed, and autogenous cartilage from the patient's own septum was used to build up the dorsum (fig. 5f).

Figure 6a shows in some detail the anatomy in the unilateral harelip with displacement of the lower lateral cartilage, blunting of the tip, and distortion of the nostril. The septum is almost invariably dislocated to the normal side in the unilateral harelip. The bony maxilla is underdeveloped. As is my customary procedure in cases of this type, I used a combined procedure in this case with septal reconstruction, separation of the alar attachment, remolding of the tip, and the insertion of diced cartilage or bone to build up the underdeveloped maxilla on the involved side (fig. 6b and c). A secondary repair was performed on the lip at the vermilion border at a later date.

Summary

In summary, I shall review the goals of corrective septal surgery. What is the surgeon trying to do? What does he want to avoid? The final aim of this surgery is the restoration of healthful breathing and breathing that is comfortable for the patient. The aims should be:

1. Restoring the septum to the midline
2. Maintaining a normal semirigid partition, and not producing a flaccid septum
3. Retaining as much support as possible to resist subsequent trauma
4. Preventing the complications of saddle deformity, columellar retraction, et cetera
5. Preventing postoperative septal perforations
6. Preventing postoperative stenosis
7. Avoiding interference with growth in children by a minimal disturbance or removal of normal structures

I have attempted in this presentation to review modifications and newer methods in septal surgery with the hope of providing the otolaryngologist with some technics which he can use in his own cases. I hope also that the need for careful evaluation of each deformity and the application of physiologically sound surgical technics has been sufficiently emphasized.

Discussion

C. J. HEINBERG, M.D., PENSACOLA: With the upsurge of interest in rhinoplastic procedures during the past decade, increasing attention has been directed by rhinoplastic surgeons to the relationships of nasal physiology to rhinoplasty. While patients may be interested primarily in esthetic results, plastic surgeons must be equally concerned with the functional phase. Indeed, both factors should have the consideration of the surgeon at all times.

Because of its prominent position, the nose is particularly susceptible to injury. When an injury occurs, it can cause altered physiology, as Dr. Farrior has ably demonstrated, and also results in social insecurity and economic hardship.

In the management of nasal injuries in children, the first thought is of the general condition of the child; nasal repair may have to wait. Later, parents begin to worry about the visible nasal deformity. As the child grows older, he becomes aware of the deformity, and thus the foundation of a neurosis is laid which colors his adult personality. In females this anxiety actually takes command.

Nasal deformities are found in the newborn. They are developmental and traumatic. Time will not permit discussion of the embryology of developmental deformities. Nasal deformities from injury are classified as:

(1) Prenatal, from pressure on the pelvis
(2) Birth injuries, from 30 to 40 pounds uterine pressure in the birth canal
(3) Preadolescent, which are residual or traumatic, and
(4) Postadolescent, which are traumatic

Septal injuries at birth are usually only cartilaginous displacements. They are easily reduced.

Prenatal injuries of the septum with involvement of the nasal bony pyramid should be observed for three months before any attempted correction as they generally realign themselves.

Preadolescent septal injuries were formerly a serious problem. When patients with these injuries presented themselves, they were told to wait until they were 18 years of age when the nose and face were fully formed. This advice was given because the classical submucous resection affected the growth centers of the nose.

In children with luxation of the quadrilateral cartilage from the maxillary spine and blockage of nasal breathing, facial changes occur. Adenoid facies has been recognized for years, but now septal facies demands emphasis.

Neglected nasal deformities in children produce adult deformities, which Goldman calls the maxillofacial triad of crooked nose, arched palate and receding chin (micrognenia). To correct childhood septal deviations the Goldman septum, which I call septoplasty, has been of infinite value. Since this procedure does not interfere with growth centers, as no tissue is removed, it can be performed at any age. Physiology of the nose can be readily restored and adult complications prevented. The procedure is as readily amenable to correction of adult septal deviations, both cartilaginous and those involving the bony septum composed of the perpendicular plate of the ethmoid and vomer either with or without osteotomy. The technic is simple. Anesthesia in children is always endotracheal; in adults Monocaine with epinephrine 1:30,000 plus intranasal cocaine is used.

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Bayshore Boulevard at Hyde Park Avenue.

Social Security Footnotes

The government, while slow to acknowledge anything wrong with the Social Security System, underestimated the demand for benefits. Women who could obtain benefits at 62, 63, and 64 decided to do so even if the payments were less than they would be at 65. Farmers suddenly turned out to be older than expected. Some began to pay social security taxes on reported income of $4200 which exceeded their income in prior years. Then they applied for benefits after paying taxes for six quarters. Many people who had retired and were well beyond 65 years of age, dug up jobs for themselves and paid social security taxes for 18 months, thereby qualifying for benefits of from $30 to $108.50 monthly for life. Social security experts in making their cost projections underestimated the ingeniousness of the American people when Federal give-aways are as widely advertised as are social security benefits.

ABSTRACTS

Intracranial Aneurysms Complicating Pregnancy. By Rex Bleakney, M.D. South. M. J. 50: 1168-1174 (Sept.) 1957.

The author directs attention to a complication of pregnancy which requires a high index of suspicion for differentiation from the multiplicity of complaints such as vague neurologic symptoms, syncope, dysesthesia, vertigo, and headaches which may confound and perplex the patient practitioner who reviews and evaluates them. He notes the astoundingly high frequency of intracranial aneurysms complicating pregnancy, despite the paucity of cases reported in the literature, and presents a series of six cases. He advocates neurosurgical treatment if termination of pregnancy is not imminent and designates vaginal delivery, not cesarean section, as the obstetric treatment of choice. When these lesions are present, therapeutic abortion should not be considered. He mentions anesthetics of choice and stresses the importance of recognition of the early signs.

The Lesion of Morton's Metatarsalgia (Morton's Toe). By Thomas M. Scotti, M.D. A. M. A. Arch. Path. 63:91-102 (Jan.) 1957.

The purpose of this paper is to emphasize the nature and pathogenesis of the lesion which is associated with a fairly common syndrome referred to as "Morton's toe" or "Morton's metatarsalgia." The literature tracing the development of the present knowledge of this subject is reviewed, and the clinical and pathologic features of 17 cases of this entity are presented.

The syndrome occurs more frequently in women and is characterized by neuralgic pain in the foot, usually beneath the heads of the third and fourth metatarsals. The initiating cause of the disease is believed to be trauma from weight bearing, and from the use of small, high-heeled or other ill-fitting shoes. The symptoms are associated with a lesion of the plantar digital nerve, usually the fourth, which is commonly referred to as a neuroma. The nature and pathogenesis of this lesion are discussed at length.

Therapy consists of a trial of conservative measures, such as the use of arch supports and special shoes, but curative therapy is considered to be surgical removal of the affected portion of the plantar digital nerve.

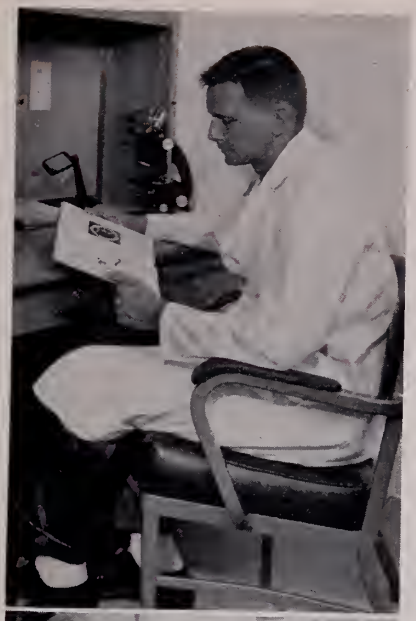
Conservative Surgery for Early Cervical Cancer in Young Women. By J. E. Ayre, M.D., Antonia Castillo, M.D., Wayne S. Rogers, M.D., and Ralph Jack, M.D. Obst. & Gynec. 10:544-548 (Nov.) 1957.

The authors make a plea for conservative treatment of preinvasive cancer in young women. They present evidence in a series of cases and mention further evidence accumulating from many clinics that it is possible to save the uterus and preserve the reproductive function of the young woman harboring preinvasive carcinoma of the cervix. The ring biopsy procedure followed by electroconization enables precise tissue confirmation of positive cytologic diagnosis essential to prove noninvasion. The same surgical procedure will effectively extirpate the localized malignant lesion in their opinion. They state that the safety of this conservative surgery is assured provided adequate histologic sections prove that the malignant process is localized and preinvasive, and provided further that long term cytologic follow-up demonstrates that the lesion has been permanently and completely extirpated. This specialized precise method of dealing with early cancer they regard as a significant forward step in eliminating the destructive effects of treating malignant processes in the female reproductive system.

Drug Reaction Times During Surgery and Anesthesia. By Nathan Glover, M.D., Ph.D. and Phillip S. Marcus, M.D. South. M. J. 51:478-481 (April) 1958.

The concept of drug reaction times and its application to anesthesia and surgery is introduced. A method is described wherein succinylcholine is used. The results in 26 adult surgical patients are presented. In 14 patients both succinylcholine and sodium fluorescein circulation times were obtained. These objective methods for the determination of circulation time in anesthetized patients may serve as diagnostic aids in the continuing management of the poor risk patient during surgery.

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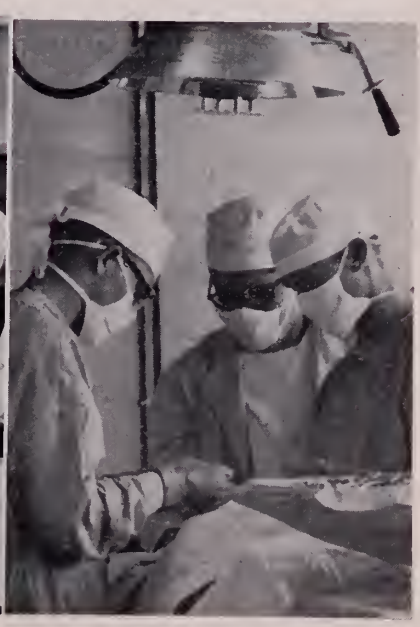




Medical Education in Florida







University of Miami School of Medicine

HOMER F. MARSH, PH.D., DEAN

It is a pleasure and a privilege to use this means of reporting on the activities and current status of the School of Medicine. Although many Florida physicians are familiar with the School and its programs, there exists a difficulty of communications with those who have no particular occasion to visit us and to become acquainted at first hand. It is difficult to present a comprehensive report in limited space; yet the following highlights may give some feeling of the School and its work.

As in any undergraduate medical college, students, instructional programs, and faculty constitute the core around which the School's activities are centered. The ultimate stature of the School is largely dependent upon its graduates and their application of training received as undergraduate medical students.



Dr. Marsh

Alumni

CLASS OF 1958.—On June 11, the School's third Class was graduated, and its 58 men and one woman members lacked only one of exactly doubling the total alumni body size. The graduates of 1958 scattered to all parts of the country for their year of internship before entering private practice or further graduate training in the specialties. Almost one half (26) elected to remain in Florida. Thirteen of these are at Jackson Memorial Hospital in Miami, six are at the Duval Medical Center in Jacksonville, three are interning at Mt. Sinai Hospital in Miami, two chose to go to the Tampa General Hospital, and one is at the Orange Memorial Hospital in Orlando. The second largest contingent, nine, went to two hospitals in that other fabulous state, California. There are five in various hospitals in Georgia, and one or two in each of 12 additional states. One, serving his military obligation, was assigned to Tripler General Hospital in Hawaii. It is gratifying to know that the majority of graduates chose hospitals closely affiliated with medical schools for their internship periods.

CLASS OF 1957.—As members of this Class have just completed their year of internship at this writing, they have not informed us of present locations and activities, but a survey of the Class of 1956 probably is indicative of what may be expected in so far as the Class of 1957, and others, is concerned.

CLASS OF 1956.—A survey of this Class reveals that of its 26 members, 10 are in the private practice of medicine in Florida. The remainder are engaged in graduate training in various specialties. In comparison with national statistics, this is about an average picture, with 35 to 40 per cent of the graduates each year going into private practice after internship, and the remainder into graduate training.

It is heartening to know that those who have entered private practice have done so in Florida. The School was established to provide a medical education for Florida students primarily, and it was presumed that the majority of these men and women would remain in the state for practice. The assumption is not completely true, however, for experience of other schools has shown that a fairly high percentage of students who are residents of the state in which they receive their medical education eventually leave that state for practice elsewhere. It will be interesting to follow this facet of the School in view of the number of physicians entering the state for practice each year.

Undergraduate and Graduate Students

It is discouraging to administrators and faculties of the medical schools to recognize there has been a steady decline in the number of applicants for admission over the past several years. This is not true of our School, and I expect it is not true for the University of Florida, as both are new schools in a state which, for a period of more than 60 years, had no medical school. Neither has reached a "leveling-off" peak of student applicants, and it is possible that the number of applicants will take a general upturn in the next few years and before either of them will reach the usual plateau of applicant numbers.

In addition to the decrease in numbers, it is even more disquieting to observe that the academic and scholastic qualifications of students who do become applicants are, in general, lower than those of applicants of a few years ago.

In consequence of these features, schools must "dig deeper" into application lists to put a class together. This has the effect of putting a heavier burden on the faculties, for they must devote greater energies and closer attention to the guidance of the students in order that the quality of the graduates will not suffer. There is a more tragic side to the picture, however. This lies in the increased attrition rate in the classes. It is discouraging for an applicant to be denied admission because of the quality of his preparation; yet it is doubly disheartening to him to be admitted and then realize that he cannot complete the curriculum because of his poor preparation It behooves all schools, ours included, to make every effort to attract more and better qualified students to medicine.

Despite these difficulties, our School will begin its seventh year with 80 students in the entering Class. Seventy-five of these have been drawn from applicants who have been residents of Florida for a minimum period of seven years. Five members were selected from among more than 200 nonresidents who applied for admission. This is the second Class in which a few nonresident students have been included in keeping with provisions of the law which governs the makeup of the classes.

Since the opening of the School, no more than 15 students were permitted to be selected from a single county of the state in any single class. The 1957 state legislature provided some relief from that restriction, however, by permitting more than 15 students from a single county if there was an insufficient number of qualified applicants from other counties to complete a class of 75.

In addition to the undergraduate medical students, the faculty of the School also is responsible for the training of 158 graduate physicians at the resident house staff level, and 65 at the intern level, all of whom are in training at the Jackson Memorial Hospital. The residents are participating in training programs in about 15 various specialties. The faculty also is responsible for the supervision of training of more than 40 residents in the Veterans Administration Hospital in Coral Gables, a "Deans Committee" Hospital.

Beginning in September 1959, graduate programs in the preclinical sciences of the medical school will be activated to lead to the Doctoral degree in these various fields.

Instructional Program

A year ago, this aspect was rather completely covered in a similar report, and there is little need to say much more. As previously described, it is our thought to develop close interdisciplinary relationships within the preclinical areas of the School. The semi-integrated program which was instituted two years ago has been improved and is continued for the present.

It is well to mention another facet of the instructional activity, however, and this lies in the area of the clinical teaching. We have come to wonder if the usual plan of sectioning classes at the third and fourth year levels with rotation of these sections through the various specialties such as medicine, surgery, pediatrics, obstetrics-gynecology, and psychiatry, is the most effective manner of guiding students through the clinical years. Thought has been given to the possibility of developing some mechanism of instructing all students in medicine before permitting them to rotate through the remaining specialties. To do so, it is apparent the third and fourth years will have to be treated as a single unit of instruction, and the present separation of inpatient and outpatient services will have to be eliminated. The mechanics of such a program are difficult, and although we believe the basic idea is good and sound, further study will have to be made before implementing such a plan.

Departmental Organization and Faculty

There have been two changes in the organization of the School by departments. Since the

early organization of the clinical departments, the Department of Surgery has been responsible for the services and teaching of anesthesiology and radiology. With the development of independent graduate programs in these Sections, however, it was recommended that they be given full departmental status. The Board of Trustees of the University gave its sanction for such an action, and as of June 1, 1958, the Sections of Anesthesiology and Radiology became Departments under the chairmanships of J. Gerard Converse, M.D., and Raymond E. Parks, M.D., respectively.

There have been some additions to and changes in the full time faculty of the clinical departments especially. One of the major changes concerned the Department of Psychiatry. At the end of the 1956-1957 academic year, the Chairman of the Department announced his resignation to accept the position of Director of the Council on Mental Health of New York City. At the same time, two other members of the Department resigned to accept other positions. Through the energetic cooperation of a small group of local practicing psychiatrists, acting as an advisory group, it was possible to attract John M. Caldwell, M.D., from his position as Chairman of the Department at the Medical College of Georgia, to come to Miami in the same capacity as Chairman. By the time the past academic year was begun, Dr. Caldwell had been able to reorganize his department around a number of the local psychiatrists, and to add two well qualified full time faculty members.

During the academic year, the Department of Surgery has been able to round out the full time section chairmen as follows: Ophthalmology, Edward Norton, M.D.; Urology, George Prout, M.D.; Orthopedic Surgery, Wallace Miller, M.D.; Neurosurgery, David Reynolds, M.D.; and Otorhinolaryngology, John Chandler, M.D. Since the beginning of the clinical departments, these posts had been administered by members of the voluntary faculty.

There are now about 150 faculty members in the School who are on full time duty, a number of whom are supported from extramural sources and are devoting a major portion of time to research activities in addition to teaching assignments. There still remain a few spots in the clinical departments in which additions will have to be made in the full time faculty, but by and large, the departments are rather completely staffed.

To the full time group, about 500 voluntary members add their time and efforts in both the service aspects of the clinical departments and in carrying a heavy load of instructional activity, both in the regular medical students and graduate students programs. We are deeply indebted to these men for the time which they give to the School.

Research Activity

Although research is not the primary reason for the establishment and operation of a medical school, the several medical schools in the United States carry a heavy load of such activity with support from various independent and governmental agencies. The general public has become increasingly sensitized to the needs for supporting the basic and clinical investigations into the various health hazards.

Our School has become active to the limit of its physical facilities, and as of the end of the academic year, was carrying more than 100 individual projects to the extent of almost $1,200,000 in extramural support. Although all departments are engaged in investigative work, two, the Department of Medicine and the Department of Pharmacology, account for more than 50 per cent of the support from outside sources. Their programs are broad; yet that of cancer chemotherapy receives heavy emphasis.

It was mentioned that physical facilities at our disposal limit the amount of research which can be done, and at the present time, every bit of available space is being utilized. This is scattered from a former Navy Blimp base about 15 miles south of the main campus of the University to a remodeled building adjacent to Jackson Memorial Hospital. The situation will be relieved by the fall of 1959, however, for construction was started in May 1958 on a new research building, located on the grounds of Jackson Memorial Hospital, and encompassing about 100,000 square feet of floor space. Funds for this building were provided in part from a grant of the United States Public Health Service, in part by the County of Dade, and in part from University sources. When completed, it will permit the centralization of many scattered research activities.

It is worthy of note also that the Jewish Home for the Aged, of Miami, became interested in the several activities of the School during the

year, and has included in its new construction of facilities a substantial research laboratory to be utilized by the School (Department of Biochemistry) for studies in the nutritional requirements of the aged.

Postgraduate Education

It is regrettable to the School's administration that this aspect of the School's responsibilities has not developed as rapidly as had been hoped it would.

During the summer of 1957, the Department of Medicine conducted a three month postgraduate program for general practitioners especially. The course, offered three mornings per week and at 8:00 a.m. in order that men could attend the sessions before turning to their daily practices, consisted in lectures over a number of the fields of medicine, as had been requested by the generalists.

Another course which has been offered each of four years, and which was presented during the latter two weeks in June of the current year, is that of Esophageal Speech and Organic Voice Problems. It is a course cosponsored by the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare; the State Vocational Rehabilitation Service; and the School. Each year, there have been approximately 50 students from all parts of the United States who have attended the two week session.

An arrangement has just been concluded with the Tampa General Hospital whereby faculty members of the clinical and basic departments will present an evening session before the house and attending staff of the hospital at monthly intervals during the coming months. It is planned that these sessions will be concerned more with basic subjects than with special topics.

In its effort to promote greater friendship with the Latin American countries, the School conducted a five day program in occupational medicine during the latter part of August 1958. This program, presented entirely in the Spanish language, is the second of its kind to be held at the School. It is planned that a similar program will be conducted biennially, to be directed to physicians from the South American countries.

It is our hope that during the current year it will be possible to organize a regular postgraduate department within the School for the regularly scheduled presentation of short sessions for physicians of the community and state. Unfortunately, the planning is complicated by the lack of suitable space which can be devoted entirely to such activities for several days at a time, and until this need can be met, there will be no heavy activity in postgraduate education as is required.

Faculty members are always ready to present an evening's session for hospital groups throughout the state if sufficient interest is exhibited and if adequate arrangements can be made.



University of Florida College of Medicine

GEORGE T. HARRELL, JR., M.D., DEAN

The College of Medicine of the University of Florida enters its third year of operation on the campus at Gainesville this month. The American Medical Association and the Association of American Medical Colleges have granted provisional approval at the completion of the second year of teaching. The complete program will be evaluated at the end of the fourth year at which time full accreditation is anticipated. The opening of the Teaching Hospital this fall marks the beginning of our clinical phase of operations. Our basic philosophy for the development of a medical school as an integral part of a university remains unchanged from that presented previously in The Journal. The faculty and students are deeply grateful to the Florida Medical Association for its advice and support during these early years. We now look forward to a new period of close cooperation with individual members of the Florida Medical Association who serve as family physicians of patients in the state.



Dr. Harrell

Students

The third class, which will graduate in 1962, was selected from 327 applicants, screened from over 600 preliminary applications. The 50 students in the class were selected from 115 who were interviewed personally. Seventeen women applied and two were accepted. The 44 Florida residents come from 17 counties in the state with the greatest number, 11, from Duval. One student each comes from Georgia, Oregon, Wisconsin, Connecticut, New Jersey, and New York. This proportion of out-of-state students, 12 per cent, approximates the ratio in the student body of the University of Florida as a whole. At the time of admission 17 students were married; they have a total of 13 children. A bachelor's degree is held by 42 of the students; three additional students have completed four years of college. One student holds a graduate degree at doctorate level. The scholastic performance of five students was recognized by election to Phi Beta Kappa. The class average for scores achieved on the Medical College Admission Test which is administered nationally to all prospective medical students places the class well in the upper half of all students in the nation.

The students entered from 15 different colleges scattered over the country. Slightly more than half of the students attended other colleges than the University of Florida. One third of the students are 22 years of age; the others range from 20 to 28 with a single student 31 years of age.

The third year class will continue with 40 of the original 47 students, including all three of the women. This rate of attrition is in line with national experience and is due primarily to scholastic difficulties. Santford Russell Wilson of Gainesville received the Stewart Thompson Award for scholastic performance during the first year. Samuel Walker Smith of Inverness received the Roche Award as the student who at this stage of his development best exemplifies the ideals of the modern American physician; scholarship, character, personality, and seriousness of purpose were all considered.

Forty-six of the original 50 students, including the only woman in the Class of 1961, are continuing into the second year. One student withdrew for personal reasons and the others because of scholastic difficulties. Michael J. Pick-

ering of Starke was selected from this class to receive the Stewart Thompson Award.

Selection has already begun for the 50 students who will enter in the fall of 1959.

The State Scholarships awarded annually through the State Board of Health have proved of tremendous financial assistance to students. The three students in the third year who were awarded four year scholarships continue. Five scholarships were awarded members of the Class of 1961 during their first year and a sixth has been awarded beginning with the second year. Five students in the Class of 1962 were awarded State Scholarships. One student in the Class of 1961 has held for two years a scholarship of comparable size awarded by the Edward E. and Lillian H. Bishop Foundation of Bradenton.

The College of Medicine has been particularly pleased that a large number of students are continuing their education informally during the summer by working in research laboratories of various faculty members. In the Class of 1960, six students are supported by Summer Research Fellowships and 12 by Research Grants. In the Class of 1961, 12 students have received fellowship awards and seven are working as technicians or research assistants on grants. The Student Research Fellowships are being supported by the Florida Cancer Society, Florida Heart Association, Florida Tuberculosis and Health Association, and the Palm Beach and Volusia County Heart Associations as well as the National Science Foundation, National Institutes of Health and Lederle Laboratories. These funds permit a student to try a simple project of his own and enable him to learn an investigative method of thinking which he can apply to patient care in later years.

Financial support of students continues to be an increasingly pressing problem. A beginning has been made on a long term loan fund through a generous gift of the William G. and Marie Selby Medical Loan Fund of Sarasota. The Woman's Auxiliary of the Volusia County Medical Society has added to the fund and a substantial contribution has just been received from the Kellogg Foundation. Through the generosity of members of the Florida Medical Association adequate funds for the present have been obtained for short term loans to tide students over acute emergencies. We



The J. Hillis Miller Health Center on the campus of the University of Florida, Gainesville. The Medical Sciences Building at the left houses the Colleges of Medicine and Nursing. The Research Wing will be built westward toward the left and the Pharmacy Wing northward toward the top of the photograph. The L-shaped building in the left foreground houses the outpatient clinics. The Ambulatory Wing projects forward toward the bottom of the photograph. The tallest building at the right is the Teaching Hospital. In the background is the main University campus. In the center are the new dormitories where nursing students live with other girls. To the east at the far right are new married student apartments.

are deeply grateful for the response from the profession to this need pointed out last year.

Faculty

The faculty for the basic science years has been largely selected. Two hold Markle Scholarships, awarded by the John and Mary R. Markle Foundation of New York, one in Pathology and one in Microbiology. Two are on Senior Research Fellowships of the United States Public Health Service, one each in Anatomy and Biochemistry.

In the selection of the Chairman of the clinical departments the criteria used in the selection of the basic science faculty have been followed. Men have been chosen on the basis of teaching ability and research potential. All are exceptionally well qualified, young, and enthusiastic.

The Professor of Medicine is Samuel P. Martin of Missouri, who was graduated from Washington University and received his residency training there and at Duke. The Professor of Surgery is Edward R. Woodward of Iowa, who graduated and received his residency training at the University of Chicago; he comes from the faculty at the University of California, Los Angeles. The Professor of Psychiatry is Peter F. Regan, III, who was born in New York, graduated from Cornell, received his residency training at the Payne Whitney Psychiatric Clinic and remained on the faculty at Cornell. The Professor of Obstetrics and Gynecology is Harry Prystowsky of South Carolina, who graduated from the Medical College of South Carolina, received his residency training at Johns Hopkins and served on the faculty there and at Yale. The Professor of Pediatrics is Richard T. Smith of Oklahoma, who graduated from Tulane, received his residency training at Minnesota and served on the faculty of Southwestern Medical College of the University of Texas. The Professor of Radiology is John D. Reeves Jr. of Texas, who graduated from the University of Arkansas, received his residency training at the Massachusetts General Hospital and served on the faculty of Harvard. A full time faculty at Assistant and Associate Professor level is being gathered. Individual members are currently abroad in Sweden, Canada, and elsewhere receiving additional specialized training.

Members of the faculty are assuming increasing responsibility nationally as members of National Advisory Councils of the Surgeon General, Study Sections of the United States Public Health Service, and Research Committees of voluntary health agencies such as the American Cancer Society, and as officers of national scientific organizations.

Physical Plant

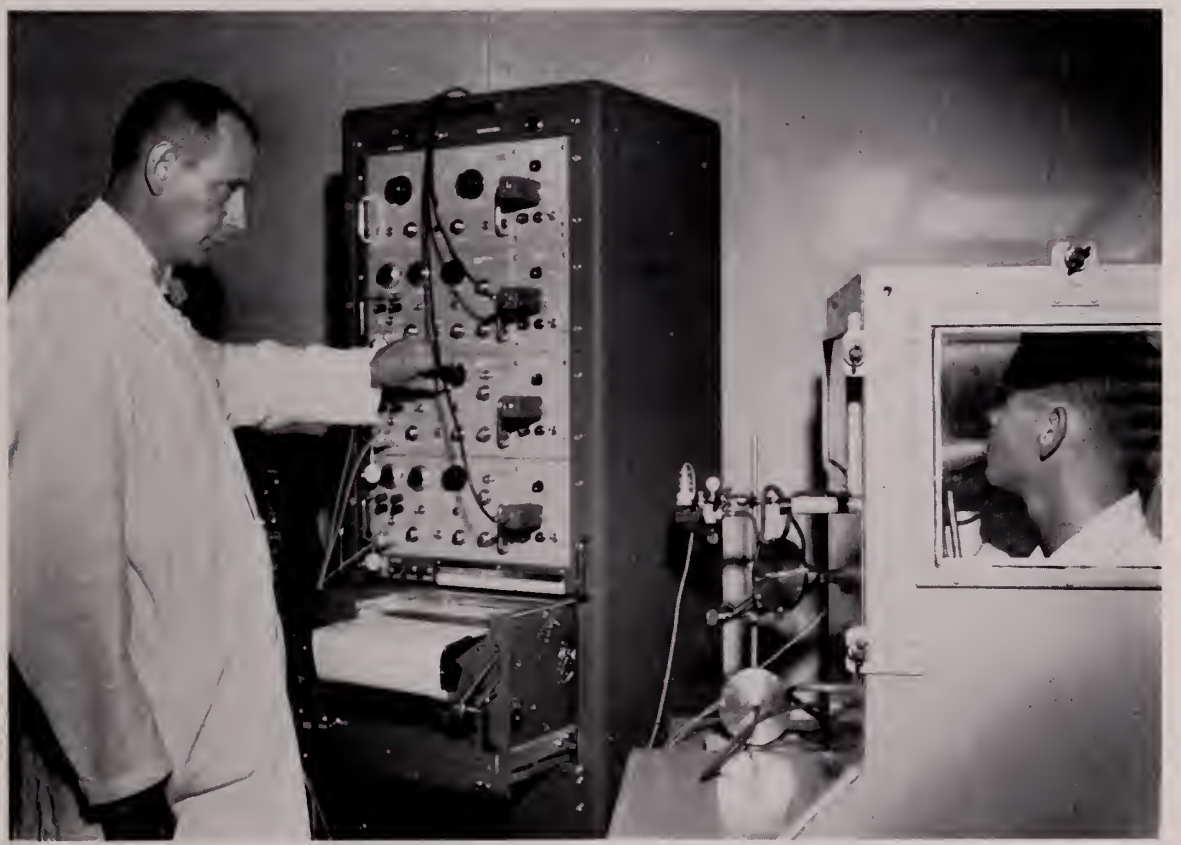
Construction of the Teaching Hospital and Clinics, which are completely air conditioned, should be completed during the fall. A ceremony for formal opening of the facilities to patients has been planned for Oct. 20, 1958. The clinical facilities are composed of three units which have been conceived educationally as the counterparts of the conditions under which a physician practices in the local community: the hospital, the ambulatory unit which creates the setting of the home, and the clinics which reproduce in principle the physician's office. The individual study cubicles for students, described last year, have been refined in design, and one is provided for each member of the third and fourth year classes. Cubicles are placed in the connecting link between the Medical Sciences Building and the main vertical axis of traffic in the clinical areas so that the student is strategically placed for ready access for all three clinical units, as well as the library and research laboratories. A teaching auditorium, of intermediate size seating 225, for clinical demonstrations has been placed on the sixth floor to minimize the vertical movement of patients. This facility will be available for instruction of nurses and others in the health professions as well as medical students and house officers.

Each floor of the "T"-shaped hospital has been designed for multipurpose use. At the center of the "T" are found teaching and service areas. The teaching facility is composed of a functional nursing station, a small work and charting room for students, another for house officers, and a classroom seating 16. The classroom can be divided to provide a separate treatment room or can be used full size for instruction in procedures such as thoracentesis, or for night admission of patients, and treatment of critically ill patients such as those in diabetic coma. The procedure room adjoins the floor laboratory so that correlation of clinical and laboratory findings is emphasized. Immediately across the corridor from the teaching area, for quick access by students, residents, and nurses, are four two bed rooms which will be used for single critically ill or terminal patients.

Separate work areas are provided for nursing aides, janitors, and food service personnel. Food and most supplies reach the floor on dumbwaiters which open into rooms so that noise is

trapped and does not reach patient rooms. The elevators in the main vertical axis are located at the end of the corridor and are separated from the ward by doors. By this arrangement the noise which reaches the floors should be reduced to a minimum. Most patient units contain two or four beds and each has a half-bath. Two single rooms with a full bath are located on each floor. A unique feature of the four bed wards is a dressing cubicle containing built-in wardrobe, lockers, mirror and lavatory. All rooms are arranged with a pillow speaker for each bed so that the patient can choose between two radio programs, taped music, or special programs which may be initiated in the hospital chapel or other areas. Microphones and speakers connected to the intercom system at the nursing station are recessed into the ceiling of each room. The fourth, fifth, and sixth floors of 64 beds each are identical so that the student will feel immediately at home regardless of the service on which he may be working. Special facilities for Obstetrics, including newborn nurseries, have been placed on the third floor. A unique feature of the delivery suite is the provision of small sitting rooms for the husband and medical student off the labor rooms and out of the traffic flow of the main corridor. Nurseries and toddler size rooms are found on the seventh floor for Pediatric patients and special facilities with large day rooms are provided on the eighth floor for Psychiatric patients. No distinction has been made on the placement or furnishing of rooms in relation to the amount or mode of payment for hospital care.

The patient floor of the ambulatory unit is a unique feature of the plant since it has been designed as an integral part of the teaching facilities. The 26 rooms, each for two persons, have been furnished with day beds and motel furniture to capture the flavor of the home rather than the hospital. Patients admitted to this unit will be followed medically in the clinics and may have a member of the family stay with them in the room. The patient will be free of hospital routine to come and go, walk to his meals in the hospital cafeteria, take his own medications, and do his own preparation for diagnostic studies as he would in his own home. The types of



A faculty research project in the Department of Medicine. The study of the mechanics of respiration uses a first year student as the subject.

patients who may be handled in such a unit include those who need a short period of hospitalization to complete diagnostic studies, control the regulation of diabetes, promote rehabilitation of handicap, or receive psychotherapy for emotional disturbances. It will also be possible to move convalescent patients out of the acute wing into the ambulatory facility as a transition from complete bed care to full activity in the community. By this technic students can get the feel of care of illness in the home. Bedside food and nursing service will not be available, though both could easily be provided if necessary. The labor involved in these two items constitutes the largest part of the cost of hospital care so that the operation of the unit will constitute an experiment in reduction of the cost in medical care.

Adjacent to the teaching unit and close to the visitor's waiting room on each floor is a unique instructional area for patients and their families. This unit is essentially a four room apartment with living room, kitchen, bedroom, and bath components furnished with home equipment. Here a patient and a member of his family can be instructed in continuing care of the illness after he leaves the hospital. The location is intended to emphasize in the student's mind the fact that discharge instructions for continuing care must be planned in such a fashion that they are acceptable to the family and achievable by them with their physical and economic resources. The bedroom can be used at night for the house officer on call to sleep on the ward. By exchanging the function of the bedroom with a standard patient room across the hall, short term metabolic studies can be done on one to two patients since the apartment has a kitchen where food can be weighed and prepared, a bath for collection of specimens and a floor laboratory. The family education unit on the third floor is readily available for instruction of ambulatory patients and the elements of the units are also found in the clinics.

The clinics have been designed to capture the flavor of Florida indoor-outdoor living. Waiting rooms have been arranged around a walled patio. The flow of traffic has been arranged so that the family and visitors can be separated from the patients as they enter the clinics. The separate waiting area can be used at night by ambulatory patients who are housed in the same wing. The educational facilities have been designed as a general clinic which is adaptable to the care of most patients. A few special facilities for Pediatrics, Otolaryngology, and Dentistry have been provided. A large rehabilitation area on the floor under the general clinic has been designed as a regional center for the training of personnel and the care of difficult problems which cannot be handled adequately in a local community. The rehabilitation area was completed with funds supplied by the United States Public Health Service and included allocations originally made to other Southern states. The professional staff is headed by Dr. Harriet Gillette, who did general practice in a small Florida community before taking specialty training in Physical Medicine and Rehabilitation.

A large emergency treatment area has been completed. It is placed adjacent to the major outpatient clinic which could then be used as a disaster ward in case of war or catastrophy. The patient flow in the emergency area has been planned as in the clinics. In addition to treatment and emergency operating rooms, a four bed observation ward for a few hours' stay and sleeping facilities for both house officers and students have been provided.

Access roads to the campus and state highway are under construction. The State Road Board has planned a revision of State Route 24 (Archer Road) to separate fast-moving highway traffic from slow-moving hospital traffic. The traffic patterns have been planned so that patients and visitors approach the Hospital and Clinics directly from the state highway. Ambulances will use a separate entrance at the emergency area which can be reached by a different route from the state highway or from the campus. Supplies will be received at a loading dock on a lower level in the delivery court. The connecting wing between the Medical Sciences Building and the Hospital blocks sound originating outside the building at the ambulance and delivery areas from the patient floors of the acute wing. At night the entrance will be through the emergency area.

In addition to the lot already in use for the Medical Sciences Building, one parking lot for 200 cars is under construction. Additional lots to hold 113 cars to the east and 310 cars to the west of the entrance are planned for the next year.

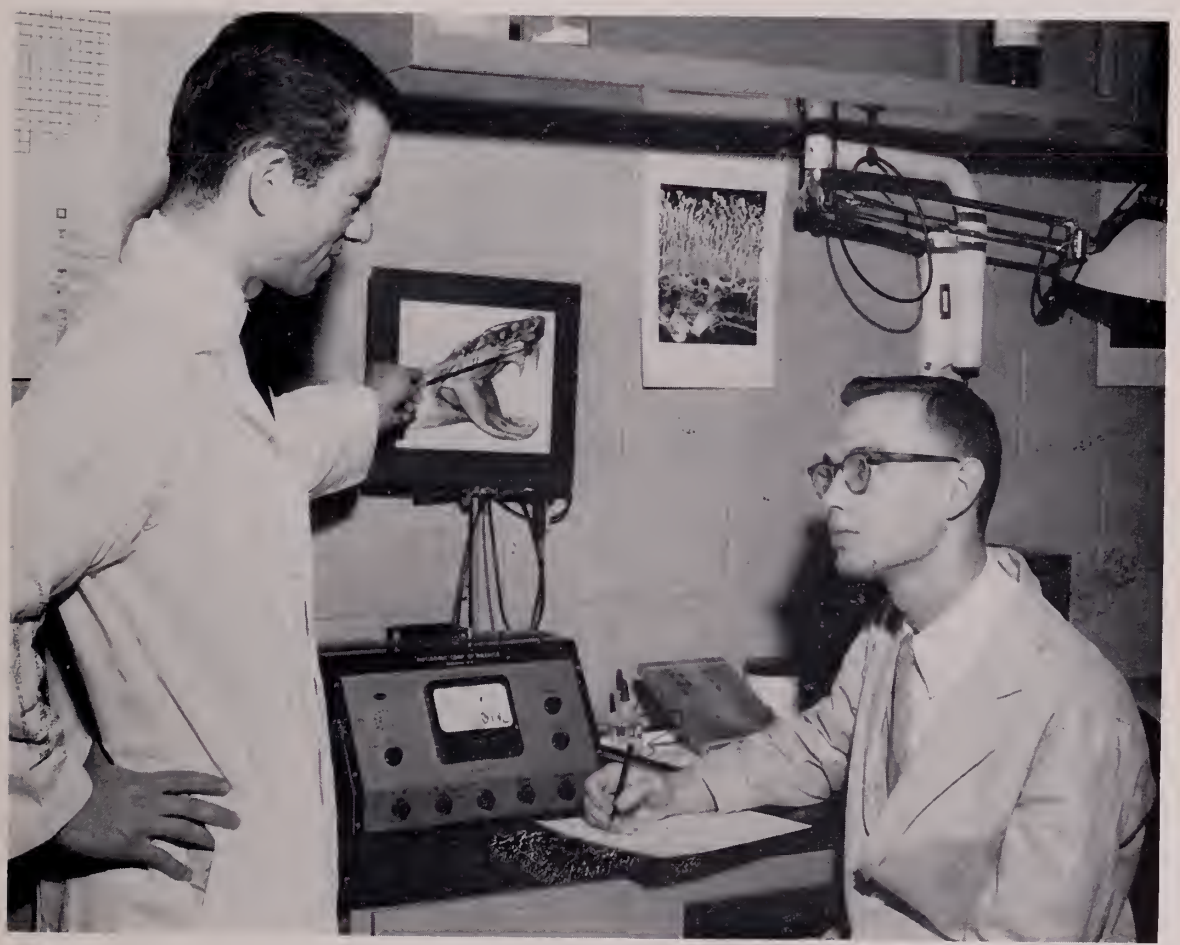
The Medical Sciences Building described last year is serving admirably as planned.

Construction of 104 apartment units adjacent to the hospital is far advanced and should be

completed by January 1959. Though planned primarily for married students and house officers, single interns and residents can be housed in groups of three or four in an apartment. At present only third year students and House Officers who are on call will have priority for these units. In line with our general University educational philosophy married graduate students from other colleges will be housed in these units as long as it is feasible. House officers will be paid a cash stipend so that they and their families may eat at home or in the hospital cafeteria as they choose.

Patients

Policies for the admission of patients to the Hospital or Clinics are being developed with the advice and counsel of the Liaison Committees of the Florida Medical Association and Alachua County Medical Society as well as our own Medical Advisory Committee. Each patient will be referred by his family physician, preferably by letter, to the Chief of Service or to a particular physician on the staff. In case of emergency, the referring physician may telephone a doctor on the staff and follow with a letter. Patients who have no family physician or who are under the care of a public health department may be referred by the county health officer. Patients injured in accidents will have the immediate medical emergency cared for; the family physician will then be contacted and his advice for further disposition of the patient obtained. Letters have already been sent to each county medical society outlining these policies. Each member of the Florida Medical Association will receive a personal letter in the early fall. A patient handbook is in preparation which should prove useful to referring physicians in discussing admission with their patients. By law, the Hospital must be as nearly self-supporting as possible. Payment for hospitalization can be arranged through the indigent hospitalization program, Blue Cross or other insurance, or the patient, family and friends



A student research project in the Department of Anatomy. A second year student working with a faculty member is studying the incorporation of radioactive I^{131} into the venom of poisonous Florida snakes.

may arrange for individual payment. Members of the faculty may see patients in consultation with Florida physicians or those in practice elsewhere.

The Teaching Hospital and Clinics are expected to receive the first patients for admission on Oct. 20, 1958, unless unforeseen construction delays or other complications arise. Advance reservations and requests for appointments may now be made with the chiefs of the various clinical services. The plans call for opening 100 beds in the acute hospital, and the 56 beds in the ambulant wing. Depending upon the speed with which well qualified staff can be chosen and trained, approximately 50 additional beds will be available each quarter until the entire 400 beds are in use.

Equipment

The equipping of the basic science wing of the Medical Sciences Building has been completed; laboratory furniture is being installed in the clinical wing and should be completed by spring. The Atomic Energy Commission has furnished funds to equip one laboratory so that teaching involving isotopes can be integrated into the basic science years of the curriculum; this laboratory will be in operation with the opening of the new school year.

Most major equipment has been installed in the Teaching Hospital. Special laboratory, x-ray and operating room equipment will be installed during the fall and winter.

Curriculum

The curriculum for the first and second years is undergoing minor adjustments and refinements. The initial inpatient clerkship in the third year will be general in character, regardless of the floor or service to which the students may be assigned. The greater part of the time in the third year will be spent in the general clinic. Most outpatients will be seen in this clinic where consultation will be available daily with senior faculty members of all departments. Certain cases may then be referred to specialty clinics. Inpatient clerkships on special services and electives are planned for the fourth year.

Postgraduate

The first seminar on recent advances in a clinical specialty has been held as projected in The Journal last year. A progress report in more detail will be found elsewhere in this issue on page 304. As the Hospital is opened, many teaching exercises will be available for practicing physicians in the area, and we anticipate that they will take advantage of the opportunities for continuing postgraduate education.

Residency programs in the major services are being established and residents are already at work in research laboratories. Since the Hospital was not scheduled for completion by the traditional July starting date, no interns were appointed this year. Internships will be activated by next year.

Four postdoctoral fellows, graduates of medical schools in Switzerland, Sweden and Japan, are spending one to two years in the basic science departments of Microbiology, Pharmacology, and Physiology. These men will return to their clinical services abroad.

Faculty members from medical schools in Latin America have taken specialized training in particular research technics in use in our laboratories.

Research

Research is in progress by faculty members in all departments. Up to the present, the research has been basic in character and largely conducted in Gainesville, though for special projects faculty members have gone to Mount Desert, Montreal, the high altitude station in Peru, and elsewhere. One member is spending the summer in Italy reviewing in the original medieval manuscripts. Support for research has come from voluntary health agencies in Florida, as well as the national organizations, the armed services, and various federal agencies. We are particularly pleased to have several unrestricted grants from industry. The level of research in progress remains at roughly $500,000 annually.

Excellent research is being done by students working on summer research fellowships. Some projects started last year have shown sufficient promise to continue throughout this year. Other students have worked as technicians or research assistants in various research laboratories. More students have requested such opportunities than we have been able to support with the funds available.

The first papers on research done entirely at Gainesville have been read at national meetings.

To insure more careful control of experimental animals, a full time doctor of veterinary medicine has been added to the staff.

Nursing

Though the College of Nursing is entirely separate from the College of Medicine administratively, its students use the same teaching facilities. Some instruction has been carried on in the Alachua General Hospital so that students may have practical experience in a community hospital. The faculty are all actively practicing as volunteer staff nurses in the Alachua Hospital and will continue to practice in our Teaching Hospital after it is open. This pattern parallels the familiar one of physicians who teach through actual patient care.

Each full time faculty member is engaged in research. Some projects involve direct care of patients, while others are done in cooperation with scientists, either biological or social, elsewhere in the University. A major research project involves a psychiatric training grant which includes a study of student attitudes from the point of view of a behavioral science with a psychologist as the project leader. The College of Nursing will have available in the Teaching Hospital a special four bed research ward.

Other Services

The College of Health Related Services mentioned last year has been established. The staff of this college will train students in physical and occupational therapy, medical technology and vocational rehabilitation counseling for which curricula have been approved. Other curricula in x-ray technology, clinical psychology, and other fields are under study and may be activated within another year or two. The students in this college will use the same teaching facilities in the Medical Sciences Building and Teaching Hospital provided for medical students.

Needs

Additional financial support for students is urgently needed. The long term loan fund should be rapidly and substantially increased. The College of Medicine would like to have some scholarships of its own. We would like to emphasize intellectual attainment and award some on merit alone. Increased support for summer research work of students costs little money, accomplishes much, and should be encouraged. A few research fellowships for exceptional students should be obtained to permit continuation of promising projects throughout the year.

Research space for the new faculty is urgently needed. The 1957 Legislature appropriated approximately 1.4 million dollars for a Pharmacy Wing to be built contiguous with the Medical Sciences Building. A grant of $540,000 for a medical research wing was obtained from the Public Health Service so that the construction might begin simultaneously with the Pharmacy Wing. Plans have been drawn, and we are awaiting release of the appropriation by the Cabinet. If the appropriated funds are not made available by Dec. 30, 1958, the grant will revert.

A relatively simple and inexpensive animal farm and storage facility for long term animals is urgently needed. Space for breeding colonies required by special research projects is not available in our present building. This animal facility would improve the use of the present animal quarters in the Medical Sciences Building and would supplement the expansion anticipated in the research wing.

A critical need is an increased supply of superior students. Recruitment could begin at high school level since the last teaching institute of the Association of American Medical Colleges revealed that 40 per cent of entering medical students have decided on medicine as a career while in high school. Physicians, in cooperation with the principal and counselors in the high schools, should strongly support the improvement of teaching of science. In this fashion more superior students can be interested in all health fields.

Future

The present physical plant has been so designed that should the size of classes increase to 64, additional faculty offices and research laboratories can be added to the clinical and research wings. If classes are further increased, new teaching laboratories must be built at the junction of the basic science and research wings. A social and behavioral science wing which could house the College of Health Related Services as well as certain portions of the medical faculty could be built adjacent to the clinical wing of the Medical Sciences Building.

The foundations and basic facilities in the Teaching Hospital have been so constructed that three additional floors could be added in the future to the Ambulant Wing and three to the acute wing. With these additions the bed capacity could be increased to 750 which would adequately handle classes of 64 medical students and those

in other health fields. The outpatient clinics have been so designed that they can be extended to double the present size without rearrangement of roads, parking, or present buildings.

Our goal remains the development of a true University College of Medicine as an integral part of our state educational system so that we may train better citizens, better physicians and more health personnel at all levels for Florida and this region.

Postgraduate Education at the University of Florida College of Medicine

Progress Report

WILLIAM C. THOMAS JR., M.D.

GAINESVILLE

A prospectus for postgraduate medical education at the College of Medicine and Teaching Hospital of the University of Florida was published one year ago in The Journal. The outlined program emphasized the need for presenting to physicians recently acquired knowledge in medicine and related health disciplines that had application to the understanding and management of clinical disorders. Furthermore, it was proposed that this objective might be accomplished by an annual series of seminars (one seminar for each clinical speciality) devised to inform the physician of recent developments in a particular branch of medicine. Such seminars would supplement more highly specialized courses to be offered for physicians who wish advanced training in a special subject.

The program was started in June of this year when the Division of Postgraduate Education in the College of Medicine held a well attended three day seminar on new development in renal, thyroid and respiratory disorders. A surgical symposium will be conducted in February 1959. Also, in the spring of 1959 a two day meeting devoted to selected topics in gastroenterology and hematology has been planned. Detailed information on these courses will be published soon. During the next year seminars in pediatrics, obstetrics and gynecology will be inaugurated. Within two years the clinical departments will have available facilities for advanced training in a variety of subjects.

Assistant Professor of Medicine and Director of Postgraduate Education, College of Medicine and Teaching Hospital, University of Florida.



Dr. Thomas

Full development of this program will require several years. During the coming academic year, however, completion of the Teaching Hospital and staffing of the clinical departments will provide additional educational opportunities. All physicians are welcome to attend the clinical conferences and guest lectures. A calendar of these hospital and medical school activities will continue to be sent to all physicians and hospitals of the state. The lounge for visiting physicians is located in the Medical Sciences Building, and a secretary is available to arrange appointments and conference visits.

A number of organizations in Florida are actively interested in postgraduate medical educa-

tion. During the past year the College of Medicine has, with the assistance of the Florida State Board of Health and the Committee on Medical Postgraduate Course of the Florida Medical Association, cooperated with the Northeast Florida Heart Association and the Florida Diabetes Association in planning the programs for their annual meetings. It is hoped that the College of Medicine can continue to be of assistance to these and other groups interested in promoting the best in medical care of the patient.

Two other aspects of the postgraduate educational program warrant comment. The participation by staff members of the medical college in various scientific conferences and local medical society meetings throughout Florida should do much to keep the physicians cognizant of current practices and concepts at the University Hospital. Morever, such activities provide an opportunity for the staff members to become better acquainted with the physicians of the state and thereby maintain an understanding of the future needs of the medical student and hospital resident.

It is anticipated that the program outlined for postgraduate education will be inadequate to satisfy the needs or desires of Florida's physiccians. It is hoped, therefore, that such omissions will be brought to the attention of this Division where every effort will be made to promote the physicians' ever continuing education.

EIGHTY-FIFTH ANNUAL MEETING, BAL HARBOUR

May 2 - 6, 1959

Do you have a paper, film or scientific exhibit you would like to present at the Florida Medical Association's Eighty-Fifth Annual Meeting? The deadline for application is November 1.

For scientific papers—an abstract of 50 words should accompany application

For Films—a short description with application

For exhibits—send brief resume of subject and photograph or sketch with application.

To be assured a place on the program, contact Lawrence E. Geeslin, M.D., Chairman, Committee on Scientific Work, P. O. Box 2411, Jacksonville.

PRESIDENT'S PAGE

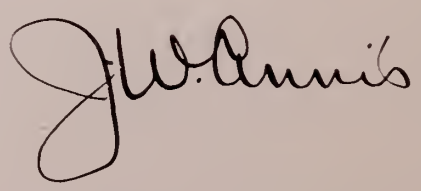
Medical Education

Elsewhere in the pages of this issue of The Journal, you will read articles by the heads of our two great Medical Schools on the subject of "Medical Education." I certainly hope that you will peruse them with the careful attention which they merit. For my part, I would only garnish these authoritative presentations with a few fragmentary thoughts of my own.

Medical education means to me the total and complete training of the individual in all the several areas which contribute toward the production of the practicing physician. Certainly the didactic education, the technical training, and the basic sciences, which comprise the bulk of the modern medical school curriculum, are vitally important, and yet, in themselves, capable only of producing a technician—not a doctor. We *need*—each of us—these fundamental facts and principles with which to fashion the foundation upon which we will erect our own modest temple of Aesculapius—we need this—and more. Let us never confuse mastery of pure science with the Science and the *Art* of medical practice—nor let us forget that it is more important that we are doctors than that we are highly skilled, highly trained—and highly restricted—technical specialists of one sort or another.

We can look back—and look up—to the giants in pure science and scientific discovery. The great men of the past who have changed the course of history with their momentous achievements—the Pasteurs, the Huxleys, the Agassizes, and the Grays. Gazing in awe at these men, we may say, as the French officer said of the Charge of the Six Hundred, "C'est magnifique, mais ce n'est-ce pas la guerre"—it is splendid, but it is not the business of a practicing physician—and training practicing physicians is the aim of medical education and of medical schools. Nearly one hundred years ago, Dr. Oliver Wendell Holmes, speaking to his students at Harvard University, said, "Here is a man fallen in a fit; you can tell me all about the eight surfaces of the two processes of the palate bone, but you have not had the sense to loosen that man's neck-cloth, and the old women are all calling you a fool." The bedside, as this great physician pointed out, is the greatest classroom, and a masterful practitioner—a great teacher.

As individuals, and as members of organized medicine, we have, I believe, forgotten for the most part our obligation in this process of medical education—this job of training a doctor. We have not sought out the young colleague in our midst for the purpose of easing his initiation, smoothing his road, and allowing him to draw on our storehouse of experience. We have, I fear, forgotten that portion of the Hippocratic oath which reads, "I will give instruction by precept, by discourse, and in all other ways, to my own sons, to those of him who taught me, to disciples bound by written engagement. . . ." Certainly it would be well for us to recall and to accept that small portion of the task of training the physician—which is ours by heritage—rather than leave the entire staggering job to our two gallant Deans.



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Heart Failure

Bedside Considerations

Congestive heart failure presents a classic picture easily recognized and usually responsive to treatment—responsive, that is, to the first measures used, or to the second, or maybe to the third. After this, what is to be done? It is poor refuge to conclude that the heart has just reached its limit, for actually the heart may not have changed structurally nor worsened in its ability to do a job.

When the physician is confronted with some abnormality, he naturally seeks one isolated cause to explain the defect. This is a fine approach except that it will rarely be rewarded with a simple answer. The word "pneumonia" once served for the explanation of an illness. It is obviously inadequate for it tells one nothing of the nature of the invading organism, the probable immune responses of the individual or the responses to be expected from antibiotics. The search goes on for a finer and finer end point of one cause, and yet the ramifications of contributing influences become broader and broader rather than narrower. The same is true of heart failure.

Congestive heart failure describes a symptom complex due to faulty heart function. The various manifestations relate to errors in function of organs of the body distant from the heart. Thus, digestive, cerebral, renal, and steroid derangements all appear.

The physician is led to treat the defect presented by his particular patient. This adds to the patient's comfort, and may save his life. The condition is still heart failure, however complex the manifestations may be.

The physician has a specific responsibility when confronted with a person with congestive heart failure. After bringing peace and comfort to the patient and orderly direction to the activities about the bedside, he must answer certain questions. Is there a disordered rhythm, concurrent disease, or recent treatment, which may be playing a part? These are important because a prostate causing a full bladder, the onset of pneumonia, a severe emotional insult, may any or all be factors which affect the degree of heart failure.

Is there some process which is changing the integrity of the heart muscle which may demand even more urgent attention than the failure itself? While all of this questioning is going on in his mind, he is lining up the facts before him in order to determine whether or not there is some structural defect of the heart or blood vessels which can be corrected by surgical means. The exact mechanism as to how the defect in heart function resulted in the symptoms present may not be explained, and yet there are many causal factors which must be considered.

Increased blood volume or shifting of blood to the pulmonary circulation causes such unpleasant symptoms that attention may be firmly directed toward correction of these defects, and the heart itself be neglected. The effects of mercury, Diamox, Diuril and salt restriction are most helpful. These benefits are easily measured by the patient in better breathing, diminished edema, and a full bottle. Congestive heart failure is responsive to these first measures.

Later, these easily measured benefits disappear, and errors of electrolyte balance appear. Attempts are made to correct these, and again heart failure responds to the second measures, as it did to the first. These beneficial effects may not last long. Again the search is made for some condition that can be corrected by surgery or for some disease condition which can be removed. Often these are not found. The metabolic defects and altered electrolyte balance may change the appearance of the electrocardiogram and make it difficult to determine whether new damage to the heart has occurred. Questions of potassium lack and problems of enough or too much digitalis plague thinking and add to the confusion.

The temptation now is to add more of this diuretic or that one, to counteract the effect of this drug with another one, and pretty soon the number of pills, medications, and restrictions of diet increase almost faster than the benefits go down. The heart has just reached its limit.

The patient has been helped, and he is more comfortable. This benefit is not denied. The measures used may have helped the heart in some ways and hurt it in others. At the same time, what has been done may not have been directed meticulously enough towards factors which directly affect the heart.

One more response may be gained by turning attention from matters of fluid exchange. This response may be more difficult to measure in volume of urine excretion, but the patient may be able to tell of increased enjoyment of food, less nausea, better sleep, and perhaps participation in some of the little pleasures that his more rigid regimen denied him. The patient may show a remarkable ability to pick the foods, the exertion, and the pleasures which he can unexpectedly tolerate. If search for defects, and concurrent disease, has been made, and the measures to effect loss of edema have been fully used, the patient is just where he was when he was first seen as far as the basic ability of his heart is concerned—that is, unless therapy and time have brought new damage.

A sense of hopelessness, therefore, often creeps into the physician's thinking. This attitude is not justified. All of the treatment measures mentioned and a host of others must be used, but the physician must keep the insight to know when his efforts are directed to the periphery and when to the center of his problem.

There are many small ways in which heart work can be wasted, and if these are found, the energy and strength which are saved can be used to better advantage. Emotional distress, anxiety and frustration over minor restrictions all add useless work and may hurry the progress of heart disease. Too much weight, a heavy finanical load, and a nagging relative are examples. Avoidance of such stressful factors will give a respite which may be as gratifying as a successful surgical procedure.

When a man learns what he can do and directs whatever energies he has into his most productive field, and partakes of the little indiscretions and pleasures that he enjoys, he obtains much of the fullness of life. Take away these things and add hopelessness and the discomforts of a too rigid regimen, and life dims. The heart reaches its limit. Reverse this situation and months or years will be added by the simple mechanism of applying the same factors which make for a good life whether or not heart disease is present.

Florida Medical Association Eighty-Fifth Annual Meeting

The date of the 1959 Annual Meeting of the Florida Medical Association has been announced as May 2-6. It is scheduled for the Americana Hotel in Bal Harbour, a section of Miami Beach.

Orange County Medical Society Honors Dr. Orr



Dr. and Mrs. Orr pause after having been greeted by Dr. and Mrs. Robert E. Zellner. Dr Zellner is President of the Orange County Medical Society. In another group were Dr. Ralph W. Jack, of Miami, President-Elect of the Florida Medical Association; Mrs. Tolle and Dr. Robert L. Tolle, President-Elect of the Orange County Medical Society; Mrs. Annis and Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association (left to right).

Orlando and Central Florida paid homage to Dr. Louis M. Orr at a reception given by the Orange County Medical Society on Aug. 1, 1958, at the Country Club of Orlando. The eminent Orlando urologist, recently chosen President-Elect of the American Medical Association, and his wife greeted some 450 guests, including the wives of society members, city and state dignitaries, and presidents of professional groups throughout Central Florida.

Special guests were Dr. Homer L. Pearson Jr., of Miami, chairman of the Judicial Council of the American Medical Association; Dr. Reuben B. Chrisman Jr., of Coral Gables, delegate of the Florida Medical Association to the parent body; Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, and Mrs. Annis; and Dr. Ralph W. Jack, of Miami, President-Elect of the Florida Medical Association.

Among the laity, distinguished guests included Senator and Mrs. Spessard L. Holland, of Bartow, and Mayor and Mrs. Robert S. Carr, of Orlando.

Dr. Robert E. Zellner, president of the Orange County Medical Society, and Mrs. Zellner, led the hosts in making this fitting tribute to Dr. Orr a most delightful occasion. Dr. Charles J. Collins was general chairman of arrangements and Dr. J. Cornall Howarth, chairman of invitations.

Prelude to the reception was a less formal greeting a week earlier when Dr. and Mrs. Orr arrived home by air from San Francisco, where Dr. Orr had just been elected without opposition to the highest office of American Medicine. As they stepped from the plane at the Orlando airport, they were greeted with whistles and cheers from more than 150 members of the Orange County Medical Society and their wives. There followed a five minute ovation from the large crowd at the terminal gate.

Dr. Orr is the first Florida physician to receive this high honor during the century and more since the American Medical Association was founded. The Florida Medical Association joins



Among prominent guests were Senator and Mrs. Spessard Holland, of Bartow, shown with Dr. and Mrs. Orr.

with the Orange County Medical Society in taking pride in this recognition of a most distinguished member of Florida Medicine whose elevation to the nation's highest post of medical leadership is a well deserved token of esteem in which the entire profession of the state rejoices.

Newspaper for American Medicine

A new, 16 page tabloid newspaper called The AMA News makes its appearance this month with the distribution of the first issue on September 22. It will be received every two weeks by approximately 200,000 physicians. Publication of the new newspaper is the latest of the many steps taken by the American Medical Association to increase the services it provides to the physician. This step was conceived more than a year ago when the A.M.A.'s House of Delegates requested a publication that would keep physicians informed of news in the socioeconomic field. Subsequent research revealed the need and desire for such a publication. The Board of Trustees then authorized the publishing of a newspaper as a means of improving communications between the association and its members and bringing to their attention the multitude of projects and activities carried on by their association, as well as all nonscientific news of interest to the profession.

Identified as "The Newspaper of American Medicine," the new publication will be of modern newspaper design and makeup with an easy-to-read type face. It will be edited to keep the physician informed in the socioeconomic field, concentrating on news not now carried in other A.M.A. journals. It will supplement — not replace — other publications of the association.

Regular features will include profiles of prominent men in medicine, a Washington newsletter, editorials, cartoons and humor, letters to the editor, business and investment news, sports, travel, hobbies, law and departments covering nonscientific news of special interest to the medical profession. In addition, there will be articles on a variety of subjects of interest to physicians and other professional men in medicine. Editorial material will be presented in a terse, crisp, easy-to-read style.

The editor of The AMA News is Jim Reed, long a prominent newspaperman in Kansas. Before joining the A.M.A. staff on June 1, he served as editor of The Topeka (Kan.) Daily Capital for more than eight years. During that time, the newspaper received more than 50 awards for journalistic excellence. Many of the awards were for articles and editorials pertaining to medicine. Earlier, he was associated with other midwest newspapers and radio stations and also edited the state of Kansas' monthly magazine, two U. S. Air Force newspapers and his own weekly magazine in Stockton, Calif. During World War II, he was an Air Force public relations officer. His editorials and humorous articles have been widely quoted and reprinted. The last two years his editorials on traffic safety won the National Safety Council's award. In 1957, he received the Kansas Bar Association's award for the newspaperman making the greatest contribution to the science of jurisprudence.

The publishers believe The AMA News will be distinctly different from any other publication. Its presentation of news and features will be lively, timely, interesting and practical. Its purpose will be to enlighten, and to be an actively helpful force in the lives of its readers — the physicians of America.

The American Medical Association is to be congratulated on this unique venture which promises to mark an important milestone of progress in medical journalism.

Alcohol Education in the School Health Program

The important and often controversial subject of alcohol education in the public schools is receiving increased attention by educators and physicians. A planning meeting held July 10 and 11 in Tallahassee featured discussions of basic policy questions by prominent Florida education and alcoholic rehabilitation officials and formulation of recommendations for future activities in the field.

Taking part in the meeting, which was sponsored by the Florida Alcoholic Rehabilitation Program with the cooperation of the Florida State Department of Education, was a representative of the Association's Committee on Child Health.

Current conditions and problems in teaching alcohol education were outlined and discussed by a series of speakers which included the Governor of Florida, LeRoy Collins; Mr. Thomas D. Bailey, Superintendent of the State Department

of Education, and Mr. Ernest A. Shepherd, Administrator of the Alcoholic Rehabilitation Program. It was noted that under Florida law it is mandatory that alcohol and narcotics education be taught in the public schools.

Among numerous basic policy statements and recommendations growing out of the meeting were the following: an objective of alcohol education shall be the avoidance of drinking among school children and youths and the provision of background information to assist them in making wise decisions; teaching curricula shall include aspects of the subject which apply to society as well as to the individual and shall be based on dependable knowledge; alcohol education shall be treated as part of the total school health program with primary responsibility for implementation vested in the State Department of Education; a variety of means shall be developed for obtaining improved teacher training in alcohol education.

In commenting on results of the meeting, Dr. Warren W. Quillian of Coral Gables, Chairman of the Association's Committee on Child Health, stated: "Awareness of the problem alone is a big step forward. Teachers and parents can work together to great advantage."

With the recent establishment of a school health medical advisory committee to the State Department of Education and the State Board of Health, the Association can look forward to providing increased assistance in evaluating and improving Florida's total school health program. President Annis announced on July 28 that the Committee on Child Health had been designated to serve in this capacity.

Florida Midwinter Seminar of Ophthalmology and Otolaryngology

For more than a decade, the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology, held yearly at Miami Beach, has attracted ophthalmologists and otolaryngologists from all sections of the country and from several foreign countries. It has steadily grown in popularity until it has become one of the most important winter postgraduate courses available in the nation. At its twelfth annual meeting in late January 1958, the attendance of 440 from 38 states and five from Canada represented more than a fourfold increase in the number of registrants since the course was first offered in 1947. The growing interest of Florida physicians as reflected in increased attendance has been particularly gratifying in recent years.

In the future, the Seminar will be known as the Florida Midwinter Seminar of Ophthalmology and Otolaryngology and will be presented in cooperation with the College of Medicine of the University of Florida and the University of Miami School of Medicine. The committee sponsoring the meeting will be enlarged to include the heads of the Departments of Ophthalmology and the Departments of Otolaryngology of both medical schools, who will assist in determining the policies and selecting the lecturers.

The 1959 Seminar will be held in mid-February instead of in January as in the past. The Americana Hotel in the Bal Harbour section of Miami Beach will again be the headquarters. The meeting is scheduled for the week of February 16 with the lectures on Otolaryngology being presented on Monday, Tuesday and Wednesday and those on Ophthalmology on Thursday, Friday and Saturday.

This Seminar is one of the outstanding features of Florida's expanding program of medical postgraduate education. Assured of able leadership and guidance, it should continue to grow in popularity and importance.

Postgraduate Obstetric-Pediatric Seminar Daytona Beach, Sept. 8-10, 1958

Scheduled for September 8, 9 and 10, the Postgraduate Obstetric-Pediatric Seminar will be held again this year at the Daytona Plaza Hotel in Daytona Beach. An excellent diversified program has been arranged which will be of particular interest to pediatricians, obstetricians and general practitioners. The meeting is jointly sponsored by the Bureau of Maternal and Child Health of the State Health Departments of Florida, Georgia, South Carolina and Alabama, and the Maternal Welfare Committees of the four State Medical Associations. The program is approved for postgraduate study, Category II, for members of the American Academy of General Practice.

The 10 distinguished lecturers comprising the faculty are Dr. Robert H. Barter, Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine; Dr. Willis E. Brown, Professor and Head, Department of Obstetrics and Gynecology, University of

Arkansas School of Medicine; Dr. Paul T. DeCamp, Head, Department of Surgery, Ochsner Clinic, and Assistant Professor of Surgery, Tulane University School of Medicine; Dr. Robert E. Gross, Professor of Children's Surgery, Harvard Medical School; Dr. Lawrence L. Hester Jr., Associate Professor and Acting Chairman, Department of Obstetrics and Gynecology, Medical College of South Carolina; Dr. James G. Hughes, Professor of Pediatrics, University of Tennessee College of Medicine; Dr. Thomas James, Chief of Cardiology Department, Ochsner Clinic; Dr. Mary Elizabeth Johnston, Member, Board of Directors, American Academy of General Practice; Dr. Frank H. Luton, Professor of Psychiatry, Vanderbilt University School of Medicine, and President, Southern Psychiatric Association; and Dr. Edith L. Potter, Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago, the School of Medicine.

Florida Diabetes Association October Meeting

The 1958 meeting of the Florida Diabetes Association will be held at the Balmoral Hotel in Miami Beach on October 30 and 31.

An excellent program has been arranged for this two day meeting. Topics to be presented will deal with pertinent problems in the management of patients with diabetes mellitus and recent developments in the field of carbohydrate metabolism. Among these are acute and chronic insulin resistance in patients with diabetes, the mode of action of sulfonylureas in lowering blood sugar concentration, the control of vascular complications in long-standing diabetes, and altered vitamin metabolism in patients with carbohydrate disorders.

In addition, there will be presentation of the pathophysiology of the adrenogenital syndrome and its variants, the effect of steroids, gynecomastia and the action of antidiuretic hormone.

Speakers will include Dr. James B. Field, National Institutes of Health, Bethesda, Md.; Dr. Thomas F. Frawley, The Albany Medical College of Union University, Albany, N. Y.; Dr. A. Gorman Hills, The University of Miami School of Medicine, Miami; Dr. Joseph J. Lowenthal, Director, Diabetic Clinic, Duval Medical Center, Jacksonville; Dr. Howard F. Root, Harvard Medical School, Boston; and Dr. William C. Thomas Jr., College of Medicine, University of Florida, Gainesville.

There will be a registration fee of $25, and all interested physicians are invited. For further information write to Dr. Grover C. Collins, Secretary-Treasurer, Florida Diabetes Association, P.O. Box 797, Palatka.

Dr. William T. Foley to Appear At GP Annual Assembly

The Florida Academy of General Practice again this year will present, in symposium form, four subjects of wide interest to Florida physicians, at its Ninth Annual Scientific Assembly to be held at the George Washington Hotel in West Palm Beach, October 30-November 1.

For the Symposium on Anticoagulant Therapy, Dr. Cecil M. Peek, General Chairman in charge of arrangements, has persuaded Dr. William T. Foley, Assistant Professor of Clinical Medicine, Cornell University Medical College, Diplomate of the American Board of Internal Medicine and author of numerous published treatises in the field of vascular diseases, to speak on "The Present Status of Anticoagulant Treatment of Cerebral Vascular Lesions," with accompanying motion picture. Dr. Jack P. Whisnant, Mayo Clinic, will give "Experimental Cerebral Infarction and Anticoagulant Therapy," and Dr. E. Sterling Nichol, Miami, will be another speaker.

Dr. Arnold H. Eichert, Superintendent, South Florida State Hospital, will be the moderator for Mental Illness and will introduce Dr. Melvin T. Reed, Florida State Board of Health, "Follow-up Services for Patients on Trial Visit from State Hospital;" Dr. Jack Russ, Tampa, "Management of Psychiatric Disorders in a General Practice," and Dr. Richard W. Anderson, Director of Psychiatry Outpatient Service of the University of Minnesota, "Screening and Placement of Psychiatric Disorders."

Highlighting the Symposium on Disaster Planning will be "Radiation Effects and Their Management" by Clinton S. Maupin, Col. MC, and Special Assistant to the Surgeon General of the Army for Nuclear Energy. Joseph R. Schaeffer, Col. MC, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, will give "Thermal and Blast Injuries."



Dr. Foley

The Cancer Symposium is composed of Drs. Emerson Day and Michael Deddish of New York City and Dr. Harry Southwick, Chicago, all well-known cancer specialists, with Dr. Paul J. Coughlin, Tallahassee, as moderator.

Registration will commence Thursday afternoon, October 30. There will be a business meeting and the usual intermissions to view the excellent scientific and technical exhibits. Social activities will include a luncheon and fashion show for the ladies, with a boat trip around beautiful Lake Worth. The program will conclude with a banquet, leaving Sunday for the members to enjoy the Palm Beaches, or make a leisurely return to their homes. In addition to members of the Florida Academy of General Practice, all other physicians are cordially invited to attend.

Southeastern States Cancer Seminar Tampa, Nov. 19-21, 1958

The Southeastern States Cancer Seminar will be held in Tampa on November 19, 20 and 21 at the Hillsborough Hotel. All physicians are cordially invited to attend, and credit is given by the American Academy of General Practice for postgraduate training. There is no registration fee.

An outstanding program has been arranged with nationally prominent guest speakers presenting the lectures. These include Dr. Joseph P. Concannon, Co-Director, Department of Radiation Therapy and Radioactive Isotope Laboratories, Jefferson Hospital, and Associate Professor of Radiology, Jefferson Medical College of Philadelphia; Dr. A. Reynolds Crane, Professor of Pathology, University of Pennsylvania School of Medicine; Dr. Ruben H. Flocks, Professor of Urology, State University of Iowa College of Medicine; Dr. Simon Kramer, Co-Director, Department of Radiation Therapy and Radioactive Isotope Laboratories, Jefferson Hospital, and Associate Professor of Radiology, Jefferson Medical College of Philadelphia; Dr. Stanley L. Lane, Associate Professor of Surgery, Albert Einstein College of Medicine; Dr. Joseph Vincent Meigs, Emeritus Professor of Gynecology, Harvard Medical School; Dr. James L. Pipkin, Associate Professor of Dermatology, Baylor University Postgraduate School of Medicine; Dr. James Rives, Professor and Chairman, Department of Surgery, Louisiana State University School of Medicine; Dr. Herbert E. Schmitz, Professor and Chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University; Dr. Max M. Strumia, Professor of Pathology, University of Pennsylvania Postgraduate School of Medicine; and Dr. Kenneth W. Warren, Surgeon, Lahey Clinic, New England Baptist Hospital and New England Deaconess Hospital.

Complete details of the program will appear in a subsequent issue of The Journal.

Report of Delegates 107th Annual Meeting American Medical Association San Francisco, June 23-27, 1958

The United Mine Workers of America Welfare and Retirement Fund, Social Security coverage for self-employed physicians, relations with voluntary health organizations, veterans' medical care, the Medicare program, the Association's Washington Office and over-all legislative system, the medical aspects of hypnosis and the advertising of over-the-counter medications were among the variety of subjects acted upon by the House of Delegates at the American Medical Association's 107th Annual Meeting held June 23-27 in San Francisco.

Dr. Louis M. Orr, of Orlando, was chosen unanimously as president-elect for the coming year. Dr. Orr, who in recent years has been vice speaker of the House of Delegates and chairman of the A.M.A. Committee on Federal Medical Services, will become president of the American Medical Association at the June 1959 meeting

in Atlantic City. He then will succeed Dr. Gunnar Gundersen of La Crosse, Wis., who became the 112th president at the Tuesday night inaugural ceremony in the Rose and Concert Rooms of the Sheraton-Palace Hotel.

The 1958 Distinguished Service Award of the American Medical Association was voted to Dr. Frank Hammond Krusen, professor of physical medicine and rehabilitation at Mayo Foundation, Rochester, Minn., for his outstanding achievements and contributions in the field of physical medicine and rehabilitation. For only the fourth and fifth times in A.M.A. history, the House also approved special citations to laymen for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipients of these awards were Mrs. Charles W. Sewell of Otterbein, Ind., who has spent 45 years in rural health work, and Gobind Behari Lal, Ph.D., distinguished science writer and Pulitzer prize winner.

Total registration reached 43,555, including 13,218 physicians.

United Mine Workers

Major discussion of relations between medicine and the UMWA Welfare and Retirement Fund centered on a reference committee report which concurred in a Board of Trustees opinion that final action on two resolutions adopted in December 1957 should be postponed until the final report of the Commission on Medical Care Plans is received.

One of those resolutions, Number 20, declared that "a broad educational program be instituted at once by the American Medical Association to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the 'Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund' adopted by this House last June." The other resolution, Number 24, called for the appropriate A.M.A. committee or council to engage in conferences with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

In explaining its position that final action on the two resolutions should be taken only after proper study, the reference committee said it "anticipates that the final report of the Commission on Medical Care Plans will contain recommendations serving to clarify the relationships between the medical profession, the patient and third parties, and the committee has been assured that this can be expected." The committee also urged the Commission to present its recommendations no later than December 1958.

The House of Delegates, however, by a vote of 110 to 72, adopted a floor amendment "that this section of the Reference Committee report be amended to show that our A.M.A. Headquarters Staff is directed, under supervision of the Board of Trustees, to proceed immediately with the campaign which was originally ordered at Philadelphia last December, that no further delays will be tolerated, and that the Council on Medical Service be relieved of any further responsibility in this matter."

Social Security Coverage

In considering seven resolutions dealing with the inclusion of self-employed physicians under the Social Security Act, the House disapproved of three which called for polls or a referendum of the A.M.A. membership, one which favored state-by-state participation in Social Security, and two which called for compulsory inclusion on a national basis. Instead, the House adopted a resolution pointing out that "American physicians always have stood on the principle of security through personal initiative," and reaffirming unequivocal opposition to the compulsory inclusion of self-employed physicians in the Social Security system.

On the question of polls, the House expressed the opinion that any poll should be taken on a state-by-state basis and the results transmitted to the A.M.A. delegates from that state. It also pointed out that since there is no provision in the Constitution and Bylaws for a referendum of members, such a referendum would usurp the duties and prerogatives of the House of Delegates, which is the Association's policy-making body.

Voluntary Health Organizations

Dealing with problems that have arisen in the raising and distributing of funds since development of the concept of united community effort, the House adopted the following statement offered in the form of amendments from the floor:

"1. That the House of Delegates reiterate

its commendation and approval of the principal voluntary health agencies.

"2. That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own programs of research, public and professional education and fund raising in their particular spheres of interest.

"3. That the House of Delegates respectfully requests that the American Medical Research Foundation take no action which would endanger the constructive activities of the national voluntary health agencies.

"4. That the Board of Trustees continue actively its studies of these perplexing problems looking forward to their ultimate solution."

Veterans' Medical Care

Pointing out that the federal government spent $619,614,000 on hospitalized medical care of veterans in VA hospitals in 1957, of which about 75 per cent had non-service-connected disabilities, and that ways and means of obtaining economy in federal government are allegedly being sought by the Congress at this time, the House urged Congressional action to restrict hospitalization of veterans at VA hospitals to those with service-connected disabilities. It also recommended that the American Medical Association suggest to the Dean's Committees that they restrict their activities to Veterans Administration hospitals admitting only patients with service-connected disabilities.

The Medicare Program

In disapproving a resolution calling for repeal, modification or amendment of Public Law 569, the House took the position that desired changes in the Medicare program could be accomplished through modification of the present implementing directives without the necessity for new legislation. The House reaffirmed the action taken last year in New York recommending that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. Also reaffirmed was the Association's basic contention that the Dependent Medical Care Act as enacted by the Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

Washington Office

The House adopted a resolution requesting the Board of Trustees to make an immediate survey and re-evaluation of "the functions and effectiveness of the over-all A.M.A. legislative system, including the Washington office, in the light of present day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the A.M.A. of information on all current public issues in which the physician has a direct interest." The House asked that the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of the resolution, "effective public and government relations."

Medical Aspects of Hypnosis

A Council on Mental Health report on "Medical Use of Hypnosis" was approved by the House, which recommended that it be published in the Journal of the American Medical Association with bibliography attached. The report stated that general practitioners, medical specialists and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It stressed, however, that all those who use hypnosis need to be aware of the complex nature of the phenomena involved. Teaching related to hypnosis should be under responsible medical or dental direction, the report emphasized, and should include the indications and limitations for its use. The report urged physicians and dentists to participate in high level research on hypnosis, and it vigorously condemned the use of hypnosis for entertainment purposes.

Over-the-Counter Medications

The House endorsed recommendations by the Public Relations Department that:

The A.M.A. join with other interested groups in setting up an expanded voluntary program, coordinated by the National Better Business Bureau, which will seek to eliminate objectionable advertising of over-the-counter medicines.

The A.M.A. counsel with the National Better Business Bureau in the selection of a physicians' advisory committee.

The established facilities of the A.M.A., such as the Chemical Laboratory, the offices of the

The Achievements of

Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

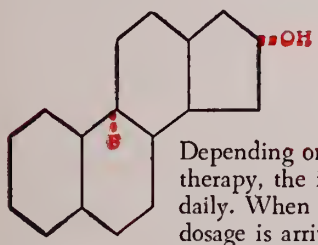
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13. Dubois, E. L.: Personal Communication.

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Triamcinolone LEDERLE

...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

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various scientific councils, and the Bureau of Investigation, be made available, so far as is feasible, to aid in the carrying out of this program.

The Public Relations Department continue its liaison work with the various groups involved and assist in the development and operation of this program in any way possible.

The A.M.A. become a sustaining member of the National Better Business Bureau, giving evidence of its willingness and desire to support this organization in its worth while activities.

Miscellaneous Actions

Among a wide variety of actions on many subjects, the House also:

Adopted amendments to the Constitution and Bylaws which eliminate the separate offices of Secretary and Treasurer, combining them into one, and which change the titles of the General Manager and Assistant General Manager to Executive Vice President and Assistant Executive Vice President;

Recommended the appointment of a Committee on Atomic Medicine and Ionizing Radiation and suggested that it concern itself with informing the American public on all phases of radiation hazards related to the national health;

Approved in principle the admission of the Virgin Islands Medical Society as a constituent society of the American Medical Association;

Commended the Federal Food and Drug Administration for its untiring efforts in behalf of the public and the profession, and urged all states to review and strengthen their food and drug laws;

Approved the "Suggested Guides for the Organization and Operation of Medical Society Committees on Aging," submitted by the Council on Medical Service;

Commended the Committee on Medical and Related Facilities of the Council on Medical Service for its report on the Hill-Burton Study and approved its recommendations;

Requested that any funds provided under the Public Assistance provisions of the Social Security Act for medical care of the indigent be administered by a voluntary agency such as Blue Shield on a cost plus basis or by a specific agency established by the medical society of the state in which indigent care is rendered;

Directed the Board of Trustees to study problems pertaining to licensure by reciprocity and to consult with the Federation of State Medical Boards in an attempt to find a satisfactory solution;

Urged all members of the House of Delegates to give full consideration to the preliminary report of the Committee on Preparation for General Practice and to submit comments and suggestions to that committee;

Expressed the opinion that some operating room experience is valuable and necessary training for all nurses;

Recommended that general hospitals, wherever feasible, be encouraged to permit hospitalization of suitable psychiatric patients, and

Approved a National Interprofessional Code for physicians and attorneys prepared by the joint liaison committee of the American Medical Association and the American Bar Association.

Opening Session

At the Monday opening session Dr. David B. Allman, retiring A.M.A. president, urged every physician to rededicate himself to the service of mankind and every medical society to strengthen its disciplinary system "to prevent the very few from besmirching the vast majority of us." Dr. Gundersen, then president-elect, said the Association is moving ahead in finding the best possible ways to serve both the public and the medical profession, and he declared there is no reason to believe that its influence and impact will not continue to grow in the times ahead. The Goldberger Award in clinical nutrition was presented to Dr. Virgil P. Syndenstricker, Professor Emeritus of Medicine at the Medical College of Georgia.

Inaugural Ceremony

Dr. Gundersen, in his Tuesday night inaugural address, called upon the medical profession to accept its full responsibilities in promoting better world health, brotherhood and peace, adding that "the time has come when medical statesmanship must be used to augment the methods of political diplomacy." Dr. Gundersen also presented the Distinguished Service Award to Dr. Krusen and the special layman citations to Mrs. Sewell and Dr. Lal. The Shrine Chanters of Oakland, Calif., provided choral numbers during the program.

Election of Officers

In addition to Dr. Orr, the new president-elect, the following officers were selected by the House on Thursday:

Dr. W. Linwood Ball of Richmond, Va., vice

president; Dr. E. Vincent Askey of Los Angeles, re-elected speaker, and Dr. Norman A. Welch of Boston, vice speaker.

Dr. Warren W. Furey of Chicago was elected for a five year term on the Board of Trustees, succeeding Dr. E. S. Hamilton of Kankakee, Ill. Dr. Raymond M. McKeown of Coos Bay, Ore., was re-elected for a five year term, and Dr. R. B. Robins of Camden, Ark., was named to fill the unexpired term of Dr. F. J. L. Blasingame. Dr. Leonard W. Larson of Bismarck, N. D., was elected chairman of the Board at its organizational meeting after the Thursday elections.

Dr. George A. Woodhouse of Pleasant Hill, Ohio, was renamed to the Judicial Council. Elected to the Council on Medical Education and Hospitals were Dr. Leland S. McKittrick of Brookline, Mass., to succeed himself, and Dr. John V. Bowers of Madison, Wis., to succeed Dr. Victor Johnson of Rochester, Minn.

Dr. R. B. Chrisman, Jr., of Coral Gables, and Dr. J. F. Burton of Oklahoma City, Okla., were re-elected to the Council on Medical Service. For the same Council, Dr. Russell B. Roth of Erie, Pa., was named to fill the unexpired term of Dr. H. B. Mulholland of Charlottesville, Va., resigned.

Three members were elected to the Council on Constitution and Bylaws: Dr. William Stovall of Madison, Wis., to succeed Dr. Stanley H. Osborn of Hartford, Conn.; Dr. William Hyland of Grand Rapids, Mich., to fill the unexpired term of Dr. Floyd S. Winslow, deceased, of Rochester, N. Y., and Dr. Walter Bornemeier of Chicago to replace Dr. Furey.

The House approved a Board of Trustees announcement that Miami Beach will replace Chicago as place of the 1960 Annual Meeting, and New York will be the site of the 1961 Annual Meeting. Action was postponed on selection of the city for the 1962 Annual Meeting.

Rising votes of appreciation were given to Dr. Hamilton; Dr. George F. Lull, retiring secretary, and Dr. J. J. Moore, retiring treasurer.

At the Wednesday session of the House the Illinois State Medical Society made another record state society contribution to the American Medical Education Foundation by turning over a check for $177,500 to Dr. Lull, president.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Registration

Total registration of Florida Medical Association members at the 1958 A.M.A. annual meeting in San Francisco was 121. Members in attendance were:

BREWSTER: William A. Rye. CANTONMENT: Frank E. Williams. CORAL GABLES: William A. D. Anderson, Harvey Blank, Reuben B. Chrisman Jr., Carl H. Davis, James K. McShane, Ben J. Sheppard, Louis C. Skinner Jr. DANIA: Fred E. Brammer. DUNEDIN: Walter H. Winchester. EAU GALLIE: Clarence R. Crandall. FERNANDINA BEACH: Henry B. Dickens Jr. FORT LAUDERDALE: Russell B. Carson, Burns A. Dobbins Jr., Donald H. Gahagen, Clifton B. Leech, Thomas L. McKee, Francis D. Pierce, George T. F. Rahilly, W. Dotson Wells. FORT MYERS: H. Quillian Jones Sr. GAINESVILLE: Edward G. Byrne, Charles H. Gilliland. HIALEAH: John P. Schilp Jr. HOLLYWOOD: Selig J. Bascove, Alexander H. Bluestone, Anthony C. Galluccio, Robert J. Patterson, Randall W. Snow. HOMESTEAD: Joseph H. Shain. JACKSONVILLE: Silas M. Copeland, Samuel M. Day, Wm. S. Manning, John H. Mitchell, Paul V. Reinartz, Eugene D. Simmons, Wilson T. Sowder. LAKELAND: Jere W. Annis, Ben H. McConnell Jr. LAKE WALES: Willard E. Manry Jr. LAKE WORTH: Alvah L. Rowe. LEESBURG: H. Durham Young. MELBOURNE: Theodore J. Kaminski. MIAMI: James A. Campbell, Milton M. Coplan, Vincent P. Corso, M. Jay Flipse, Arnold L. Kane, Harold S. Kaufman, Alexander I. Kernish, Alfred G. Levin, Lloyd R. Newhouser, Russell K. Nuzum Jr., Mary C. Patras, Homer L. Pearson Jr., William C. Phillips, Walter W. Sackett Jr., Ralph S. Sappenfield, J. Graham Smith Jr., Robert C. Welsh. MIAMI BEACH: Victor Dorf, Jacob A. Glassman, Alvin Honigsberg, Milton B. Jacobson, David S. Light, George L. Rand.

OCALA: Carl S. Lytle. ORLANDO: Rex M. Bleakney, Leland H. Dame, Carl D. Hoffmann, William H. Kelley, Duncan T. McEwan, Meredith Mallory, Louis M. Orr, Philip F. Simensky. PALATKA: Alfred P. Peretti. PALM BEACH: Lorenzo James, John Van Boven III. PLANT CITY: Alex F. Sanchez. ROCKLEDGE: Lee Rogers Jr. ST. AUGUSTINE: Reddin Britt, James J. DeVito. ST. PETERSBURG: Russell C. Bane, William C. Beach, John P. Ferrell, James F. Jones, Norval M. Marr Sr., Orville N. Nelson, Nell T. Pattengale, Edward V. Pollard, Harry F. Rolfes, Abbott Y. Wilcox Jr. SANFORD: Orville L. Barks. SARASOTA: John M. Butcher, Lloyd J. Duest, Laurence W. Gregory, A. Lamar Matthews Jr., Hugh G. Reaves. SOUTH MIAMI: John F. McKenna. TALLAHASSEE: Joseph M. Bistowish Jr., Francis T. Holland. TAMPA: Richard G. Connar, Thomas W. Dorr, J. Brown Farrior, Richard T. Farrior, Marvin B. Miller, Thomas F. Nelson, Neal J. Phillips, Mason C. Smith, Wesley W. Wilson. VERO BEACH: Vernon L. Fromang, James C. Robertson. WEST PALM BEACH: Robert V. Artola, Harry E. Bierley, Theodore Norley, Cecil M. Peek, Raymond S. Roy. WEWAHITCHKA: Harold B. Canning. WINTER HAVEN: Henry F. Keiber. WINTER PARK: Roland F. Hotard Jr.

Future Meetings

American Medical Association

The 1958 Clinical Meeting of the American Medical Association will be held at Minneapolis December 2-5. The Annual Meeting next year has been scheduled for June, 8-12 at Atlantic City and the Clinical Meeting at Dallas, Texas, December 1-4. The 1960 Annual Meeting, originally scheduled for Chicago, has been changed to Miami Beach by action of the Board of Trustees.

STATE BOARD OF HEALTH

New Program on Care Of Premature Infants

For many years the Florida State Board of Health has shared the concern of physicians at Florida's high infant mortality rate, specifically deaths among premature infants. A number of attacks have been made with a hope of reducing this toll, and with some success, but even today our rate ranks high in the list of states.

Now a new program is being developed and is in its experimental stage. It is a two part effort which will provide some of the most recent technical data for physicians and nurses. It takes into consideration the importance of the team approach by physician-nurse.

One part of the new training program anticipates a series of five day Seminars to be held at the Premature Demonstration Center, Jackson Memorial Hospital, Miami. The Seminar consists of a series of lectures and demonstrations on various phases of premature care. Included are demonstrations of equipment and its use, and discussions on feeding and skin care. Infection and its control, the handicaps of prematurity, as well as suggestions for home care, parents instructions and nursery set-ups, are on the schedule of lectures.

There are joint lectures for physicians and nurses, and some separate lectures with special clinical work. Visits for the nurses to the homes from which premature infants have come are arranged and supervised by the Dade County Health Department. Work in the premature nursery and formula laboratory is also a part of the program for the nurses while physicians are given a variety of technical experiences.

The second part of the program will include a series of one day Demonstration Clinics to be held at strategic locations in the state. They are designed to serve physicians and nurses in small hospitals in rural areas. The afternoon programs are to be for nurses and those in the evening for physicians, geared to their interests and responsibilities. They cover in capsule form many of the topics enlarged upon at the Seminar.

The Bureau of Maternal and Child Health of the Florida State Board of Health is sponsoring these programs on Care of Premature Infants with the staff of the Premature Demonstration Center and the Department of Pediatrics, University of Miami School of Medicine. During the Seminars a number of special lecturers are drawn from other departments and from the Dade County Medical Association.

The first of these experimental Seminars was held in May. The second is scheduled for November 17. The American Academy of General Practice has approved the Seminar for credit in Category I, 35 hours, for those registering and attending.

Approximately eight years ago the Florida State Board of Health with the aid of $50,000 from the Children's Bureau, and with the cooperation and assistance of Jackson Memorial Hospital created the Premature Demonstration Center. Since that time the School of Medicine has participated in this project. Approximately 3,500 babies have passed through the Center, and they have come from Dade, Broward, Palm Beach and Monroe counties.

In addition to the infants receiving care, 425 student nurses have obtained training up to the close of 1957. These included students from Jackson's own training school and from the School of Nursing, Florida State University. Also, 33 pediatric residents, 370 interns and 183 medical students (1954-1957) have had training in the Center. Numerous other educational and training programs have emanated from the Center, which, because of this, continues to receive an annual allocation of funds from the State Board of Health.

With the continuing high death rate among Florida's infants and the rising threat of hospital and nursery infection, it is anticipated that Florida's physicians will aid in the recruitment of physicians and nurses for the training opportunities offered.

OTHERS ARE SAYING

Potent Medicine

Having a captive audience and an interest in the philosophy of Medical Practice coincident with the recent release of the revised version of the "Principles of Medical Ethics" by the A.M.A. makes writing this page irresistible to me—and, I hope, thought provoking to you.

This is an era when the dignity of man is threatened by vast changes resulting from social and economic revolution, glorification of the state

dwarfing the individual on most of the world's surface, and signs of inroads of this philosophy in our own bulwark of democracy. Medicine is an integral part of this changing panorama and must also change to remain abreast of the times.

Alone and for so long, Medicine has resisted while suffering much criticism, regulations that would lead to its socialization. But recently we have acquired allies. Insurance people have come to recognize the overwhelming weight of our national social security program. More recently at the convention of the Association of Small Colleges in Miami Beach, government subsidization with ultimate control of education was recognized and rejected. Only last week the junior senator from Florida stated that our hard hit railroads needed less rather than more government control. Perhaps time will bring even more general recognition of our purpose. But we must continue to deserve allies.

Medicine can best serve its cause in the area of interpersonal relations between a patient and his physician. In a materialistic world this is idealistic thinking. But which philosophy is ultimately greater? It is in this area that the standards of propriety (rather than laws) by the A.M.A. apply. The recognition by physicians of the need to respect fully the dignity of man, to merit confidence, render devoted service, improve skills, safeguard the public welfare is, of course, basic in the practice of medicine and easily learned. To be honorable about our limitations, well trained in the art and science of medicine, considerate of the feelings and economy of the patient and truly interested in his welfare leads to self respect and confidence. This is contagious and the patient who is convinced of our desire to offer him comprehensive help will react with a sense of security and cooperation to our efforts. Respect for our profession comes from respect for us as individuals and from this comes the power needed by medicine to plan its future. Only when a reverse situation prevails will the laity shop for medical bargains. The public becomes interested in Socialized Medicine if that is what they are getting anyway. Thus the practice of medicine is reduced to a business or trade leaving it justly prey to governmental scrutiny and regulation.

Let's make no mistake about it, the future of medicine will be determined by the will of the people. Each of us is a representative of Medicine and each patient is a representative of the People. Therefore, in addition to existing strong socio-economic forces beyond individual control, it is at the level of the patient-doctor relationship that each physician can exert his greatest influence in our future.

Nelson Zivitz, M.D., President
The Bulletin
Dade County Medical Association
March, 1958.

STATE NEWS ITEMS

The Tennessee Valley Medical Assembly, sponsored by the Chattanooga and Hamilton County Medical Society, will be held at the Read House in Chattanooga, Tenn., on Monday, September 29, and Tuesday, September 30, 1958. A faculty of distinguished lecturers, drawn from the leading medical centers of the country, will present the program, which covers a wide range of subjects. The registration fee is $15, and reservations may be requested from the Chattanooga Convention & Visitors Bureau, 819 Broad St., Chattanooga, Tenn. The program is approved for postgraduate study, Category I, by the American Academy of General Practice.

Drs. Henry G. Morton, Hershel R. Stratton and William S. Hatt of Sarasota, Dr. Dunlap W. Oleson of Venice and Dr. Fred H. Albee Jr. of Daytona Beach were among the group of physicians partcipiating in the symposium on cerebral palsy sponsored recently by the Sarasota County Medical Society.

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, has been installed as president of the Duval County Chapter of the American College of Surgeons.

Dr. M. Jay Flipse of Miami has been elected first vice president of the American College of Chest Physicians.

Dr. Leo M. Wachtel of Jacksonville has been appointed to a three year term as a member of the Commission on Hospitals of the American Academy of General Practice.

Dr. James N. Patterson of Tampa attended the latter part of the annual meeting of the Amer-

ican Medical Association in San Francisco and the following week gave the American Board of Pathology examination at the University of California School of Medicine.

Dr. Eugene G. Peek Jr. of Ocala has been elected chairman of the Medical Advisory Committee of the Florida State Department of Public Welfare.

The Second Annual Convention of the American Association of Medical Assistants will be held October 31-November 2 at the Palmer House in Chicago. The Association has been approved by the state medical societies and the American Medical Association and its present membership is nearly 6,000, representing 17 states.

Dr. Robert J. Boucek of North Miami Beach, Associate Professor of Cardiology at the University of Miami School of Medicine, has received the major award of 300 pounds sterling in the Ciba international competition for studies related to aging. His paper was on "The Effect of Tissue Age and Sex Upon the Metabolism of Rat Collagen."

Eight Florida students are completing summer fellowships in heart research granted by the Florida Heart Association, the Heart Association of Palm Beach and Martin Counties, and the Heart Association of Greater Miami. The awards totaled $4,200.

The Second Oklahoma Colloquy on Advances in Medicine, devoted to arthritis and related disorders, has been scheduled for November 12-15 at the University of Oklahoma School of Medicine, Oklahoma City. Sponsors are Geigy Pharmaceuticals, Wyeth Laboratories, The Upjohn Co., Pfizer Laboratories, Schering Corp., and the Oklahoma Chapter of the Arthritis and Rheumatism Foundation.

Dr. Eugene G. Peek of Ocala has been appointed to the Florida Advisory Committee on Civil Rights by the Civil Rights Commission, an agency of the federal government.

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May 2-6, 1959
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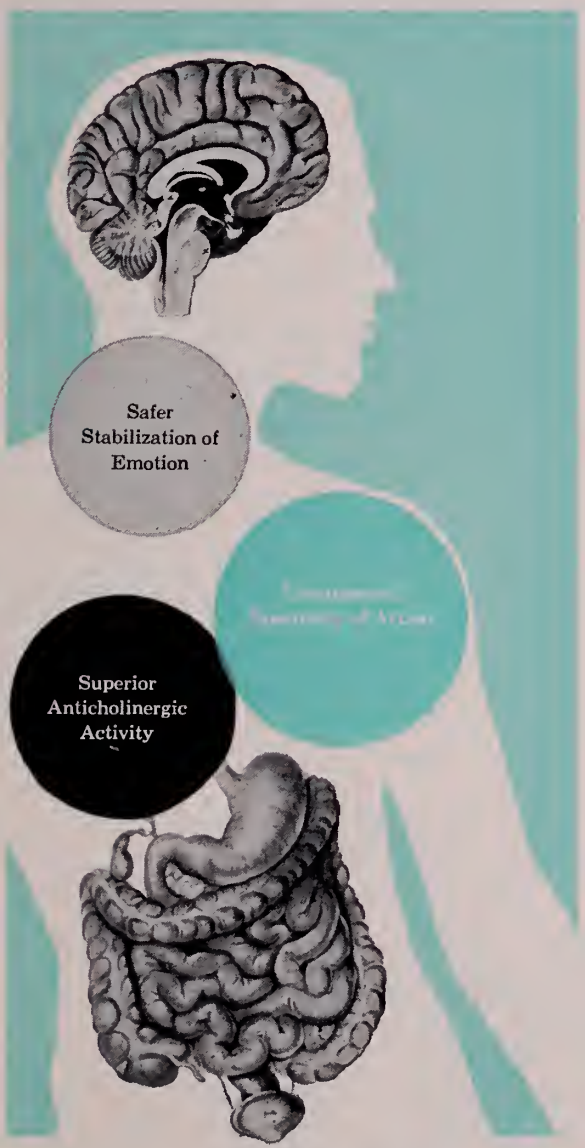
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Controls *Stress*
Relieves *Distress* *in smooth muscle spasm*

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Pro-Banthine *with* Dartal

– for positive relief of cholinergic spasm. – a new and safer agent for normalizing emotions.



PRO-BANTHINE WITH DARTAL offers you a new, specific and reliable control of visceral motor disorders, especially when these disorders are induced or aggravated by psychic tensions or anxiety.

Pro-Banthine has won wide clinical acceptance as the most effective drug for controlling gastrointestinal hypermotility and hypersecretion.

Dartal, a new phenothiazine congener, offers greater safety, flexibility and effectiveness in stabilizing emotional agitation.

The combination of each drug in fully effective doses in Pro-Banthine with Dartal gives a new means of approach to the medical management of functional gastrointestinal disorders mediated by the parasympathetic nervous system.

Specific Clinical Applications: Functional gastrointestinal disturbances, gastritis, pylorospasm, peptic ulcer, spastic colon (irritable bowel), biliary dyskinesia.

Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

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Mr. Frederick V. Altvater has been appointed acting director of the teaching hospital of the University of Florida College of Medicine. He was formerly consultant to the dean of the Duke University School of Medicine on hospital administrative problems. Mr. Charles W. Pruitt Jr. has been appointed assistant director of the hospital. He was assistant in administration in the office of the provost, Dr. Russell S. Poor, of the J. Hillis Miller Health Center.

The Woman's Hospital in New York City is offering two postgraduate courses, "Ante-partum Care" and "The Conduct of Labor and Delivery," beginning October 16 and continuing two weeks. Each course is approved for 30 hours Category I credit and is limited to general practitioners. Information may be obtained from Mr. Carl P. Wright Jr., Woman's Hospital, 141 West 109th St., New York 25.

The fourth annual meeting of the American Rhinologic Society is being held at the Palmer House, Chicago, October 17-18. Among the topics to be discussed are pulmonary and nasal physiology, laboratory and clinical aspects of bone transplants, hump removal, roof repair, and nasal process corrections.

The International College of Surgeons will hold its fourth Around-the-World Postgraduate Clinic and Lecture Tour beginning with departure from San Francisco October 10. The return will be on December 3 at New York. Sections of the College in Hawaii, Japan, Hong Kong, the Philippines, Thailand, India, Egypt, Turkey, Greece, Italy and Spain will be hosts at their clinics and hospitals. Information may be obtained from Dr. Arnold S. Jackson, 16 South Henry St., Madison 3, Wis.

Dr. William J. Clough of Tarpon Springs recently completed a postgraduate course in advanced cardiology at the Cook County Post-Graduate School of Medicine, Chicago.

The 44th annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 6-10, with headquarters in the Conrad Hilton Hotel. More than 10,000 persons are expected to attend this largest meeting of surgeons in the world. The program will feature research forums, panel discussions, closed circuit operation telecasts, medical motion pictures, cine clinics and exhibits.

The Southeastern Surgical Congress, which is holding its 27th Annual Assembly in Miami Beach, March 9-12, 1959, has announced that

(Continued on page 330)

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Dosage should be individualized.

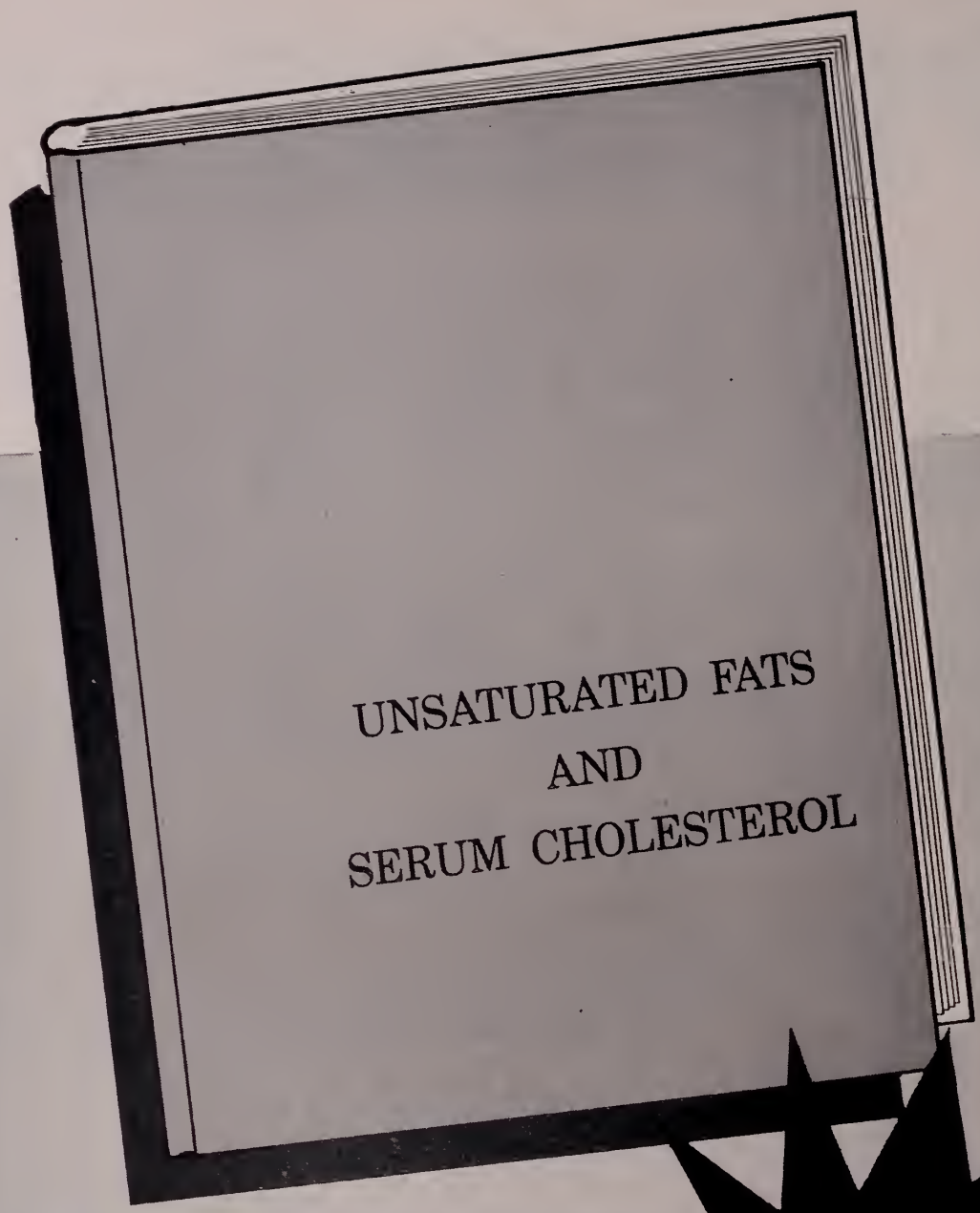
For clinical supply and literature, write Dept. 13C

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:504, *Dec. 1957.*

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MAZOLA CORN OIL, a natural food and a superior salad and cooking oil, used as part of the daily diet, can be helpful in the control of serum cholesterol levels.

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MAZOLA...the only readily available vegetable oil made from golden corn oil... is rich in the important unsaturated fatty acids. 85% of all the fatty acids in MAZOLA are unsaturated and 56% of the fatty acid content is linoleic.

As a result, MAZOLA CORN OIL is unusually well suited for helping achieve dietary adjustments commonly recommended by authorities on nutrition—that from one-third to one-half of the total fat in-take should be of the unsaturated type when serum cholesterol control is a problem.

Being a natural food, MAZOLA CORN OIL can be included as part of the every day meals—simply and without disturbing the patient's usual eating habits.

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Linoleic Acid	7.4 Gm.
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For a 3600 calorie diet	3 tablespoonsful
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(Continued from page 324)

the first prize in its Scientific Paper Award will be $100 and expenses for the author to attend the meeting in Miami Beach. The second prize is $50 and the third $25. Competition is open to resident physicians in A.M.A. approved residencies. Three copies of the paper should be mailed to the councilor of the state in which the resident is living before December 1. Name of the councilor may be obtained from the Southeastern Surgical Congress, 1032 Hurt Building, Atlanta 3, Ga.

The organizational meeting of the Caribbean Neurosurgical Society was held in Miami early in July. Dr. W. Tracy Haverfield of Miami served as temporary chairman. Physicians from several Latin American countries attended.

Dr. Richard C. Cumming of Ocala was principal speaker at a recent meeting of the Rotary Club of Clearwater. Dr. Cumming is governor of the 696th district of Rotary International.

Dr. Russell B. Carson of Fort Lauderdale, President of Blue Shield of Florida, addressed the House of Delegates of the West Virginia State Medical Association August 20 at the annual meeting being held at White Sulphur Springs. Dr. Carson's topic was "The Role of the Physician in Blue Shield."

The 23rd Annual Convention of the American College of Gastroenterology is being held October 20-22 at the Jung Hotel in New Orleans. On October 23-25, Dr. Owen H. Wangensteen of Minneapolis and Dr. I. Snapper of Brooklyn will be the moderators of the Annual Course in Postgraduate Gastroenterology. Sessions will be held in the Jung Hotel and in the auditorium of the Louisiana State University School of Medicine.



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Nicotinamide	20 mg.
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Dr. Alton Ochsner of New Orleans was principal speaker at dedication ceremonies held August 3 for the Watson Clinic at Lakeland. The new clinic was dedicated as a memorial to Dr. Herman Watson of Lakeland, a life member of the Florida Medical Association.

Dr. Simon D. Doff of Jacksonville has been appointed Director of the Bureau of Maternal and Child Health of the State Board of Health. The appointment was announced by Dr. Wilson T. Sowder of Jacksonville, State Health Officer.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was a featured speaker at the Opening Plenary Session of the XIIth General Assembly of The World Medical Association held the middle of August in Copenhagen, Denmark. The title of Dr. Orr's address was "The Biological Effects of Nuclear Radiation."

Dr. Simon D. Doff of Jacksonville has been re-elected as president of the Florida Heart Association.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Leslie R. Adams of Jacksonville announce the birth of a daughter, Catherine Teresa, on June 28, 1958.

Dr. and Mrs. Albert T. Fechtel of Jacksonville announce the birth of a daughter, Karen Marie, on June 19, 1958.

Dr. and Mrs. Thomas H. Gouchnour of Jacksonville announce the birth of a daughter, Mary Elizabeth, on June 9, 1958.

Deaths — Members

Hollingsworth, Samuel Glen, Bradenton ..... July 13, 1958
LoPopolo, Vincent C., Cross City ..... Aug. 2, 1958
Kleinman, Samuel B., Miami Beach ..... July 18, 1958

Deaths — Other Doctors

Cremin, Lawrence D., Riviera Beach ..... April 1, 1958
Gale, Joseph, Miami Beach ..... May 14, 1958

Medical Officer Returned

Dr. John N. Sims Sr. who entered military service on February 27, 1956 was released from active duty on March 4, 1958 with the rank of major, U. S. Army. His address is 337 North 4th Street, Ft. Pierce.



• postoperatively
• in pregnancy when vomiting is persistent
• following neurosurgical diagnostic procedures
• in infections, intra-abdominal disease, and carcinomatosis
• after nitrogen mustard therapy

for nausea and vomiting

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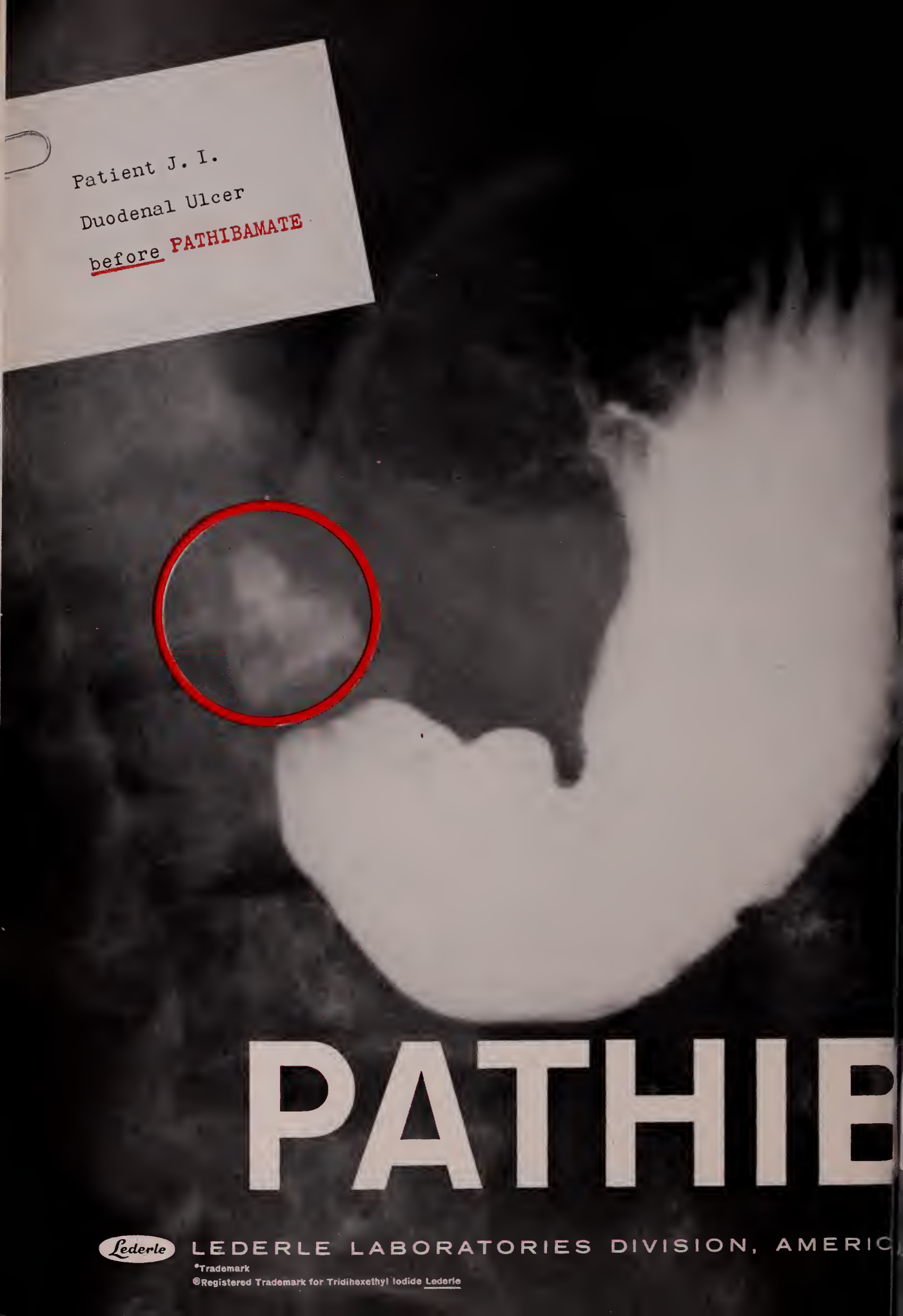
• provides prompt, potent, and long-lasting control
• capable of depressing the gag reflex
• effective in cases refractory to other potent antiemetic agents
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• no pain or irritation on injection

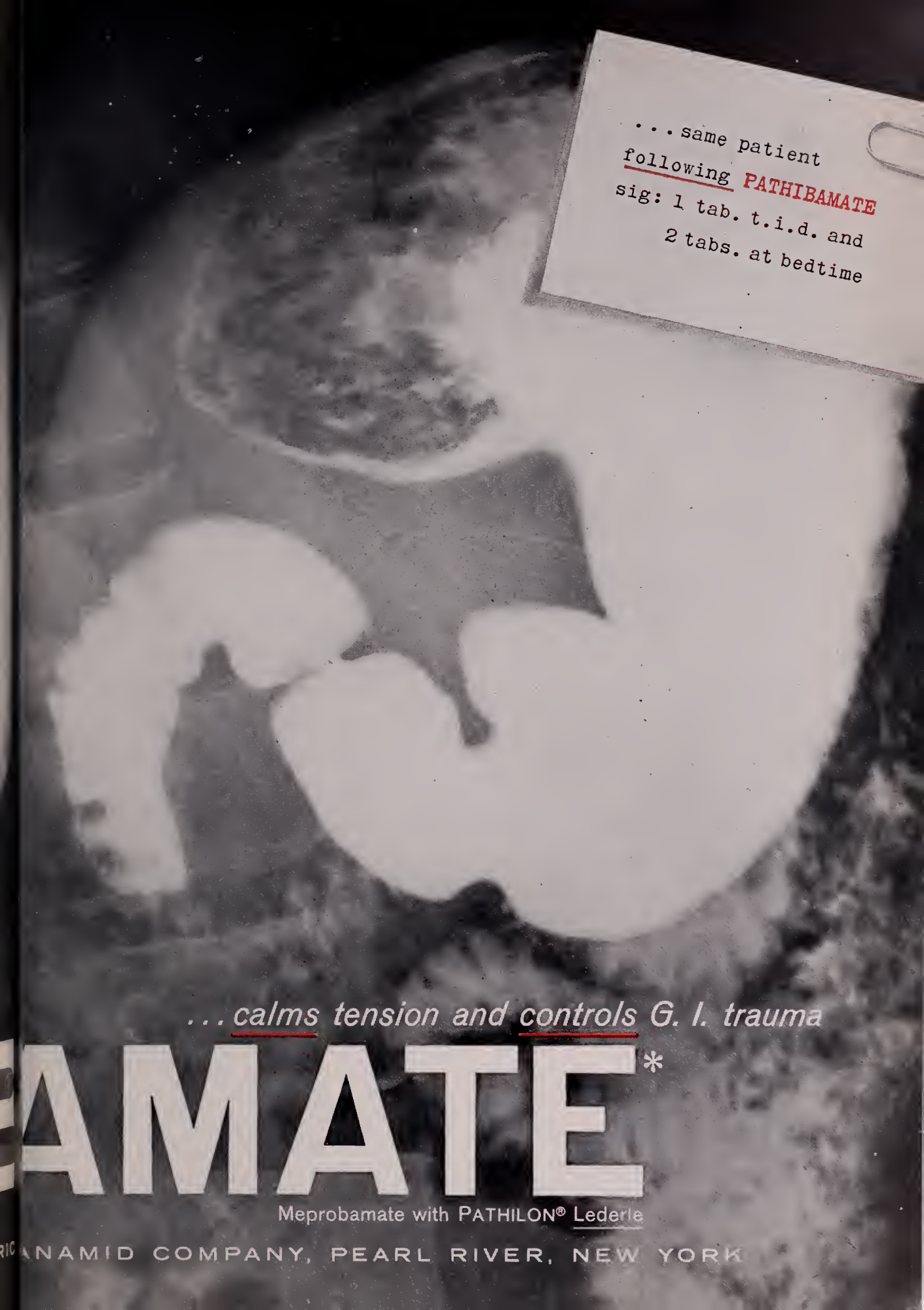
ANTIEMETIC DOSAGE:
Intravenous: 8 mg. average single dose
Dosage range 2-10 mg.
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If subsequent parenteral dose is needed, one-half the original dose will usually suffice
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. . . calms tension and controls G. I. trauma

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Adams, Charles B. Jr., Hollywood
Cowell, Virginia L., Coral Gables
Crispin, Maximilian, A., West Palm Beach
Gross, Herbert F., No. Miami
Hendricks, Charles M. Jr., Fort Lauderdale
Jacobs, Irwin S., Miami
Keith, Walter P., Winter Haven
Kullman, Donald A., West Hollywood
LaGuette, Henry F., Miami
Llanes, Carlos G., Miami
McKay, John W., Fort Lauderdale
McGrady, Charles W. Jr., Pompano Beach
McGrady, Kathleen R., Pompano Beach
Miller, Morton L., No. Miami
Rodenberg, Thomas A., Hollywood
Schilling, Robert C., Palm Beach
Simmons, Raymond J., Miami Beach
Sims, M. David, So. Miami
Tanis, Arnold L., Hollywood

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INTERNIST: Age 31; with special pulmonary training; Part I Boards completed. Three and one-half years private practice. Florida license. Married; four children. Desires association with group. Fall of 1958. Write 69-271, P. O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST WANTED: Florida group desires obstetrician-gynecologist Board Certified or Board Eligible for permanent association. Guaranteed salary and percentage with advancement to full partnership. Will work with another Board Certified obstetrician-gynecologist. Position open July 1 or before. Write 69-270, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner for well established South Florida group. Write full details of training, experience, references, etc. Write 69-273, P.O. Box 2411, Jacksonville, Fla.

FOR SALE OR LEASE: Ultra modern twenty seven bed hospital with complete operating room and delivery room and outpatient department. Unopposed practice. Reason due to recent coronary. If interested write: 69-274, P.O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner and Pediatrician to join group who owns thirty bed hospital. Consulting service once a week. Academic environment. Salary first six months partnership later. Must be draft exempt. Florida license required. Write 69-275, P.O. Box 2411, Jacksonville, Fla.

TAKE A NEW LOOK AT FOOD ALLERGENS* TAKE A LOOK AT NEW DIMETANE



DIMETANE Extentabs (12 mg. each, coated) provide antihistamine effects daylong or nightlong for 10-12 hours. Tablets (4 mg. each, scored) or pleasant-tasting Elixir (2 mg./5 cc.) may be prescribed t.i.d. or q.i.d., or as supplementary dosage to Extentabs in acute allergic situations. A. H. ROBINS CO., INC., Richmond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878.

*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

AVAILABLE SEPTEMBER 1: Medical Arts Building, 503 W. Platt, Tampa. Air-conditioned. Suitable for doctor desiring more than usual accommodations or two associated. Ground floor. Easy parking. Phone 8-1600.

WANTED: Competent, well trained General Practitioner capable of general surgery. Well established, large practice, Hillsborough county. Florida license required. Hospital privileges. Write 69-280, P.O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner and Board certified Otolaryngologist to associate with well established medical group in growing community, Florida East Coast. Florida license required. Salary first year with partnership privileges to follow. Send full details, training, experience, character reference, etc. in first communication. Write 69-276, P. O. Box 2411, Jacksonville, Fla.

FOR SALE: Established doctor's office. Fully equipped setup with additional plumbing, high voltage line. Main street, downstairs location. Attractive, expensive layout at a sacrifice. Contact J. H. Rester, M.D., 504 Lake Avenue, Lake Worth, Fla.

WANTED: A General Practitioner associate. Fully equipped own seven room private office. $10,000 guarantee, plus percentage. Privileges fully accredited teaching hospital. Early full partnership. Norwood Medical Center, North Miami 61, Fla.

FOR RENT: Medical office in Clearwater. Ground floor. Ideal location. Air conditioned. Large reception room, furnished. Write 69-287, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED: West Melbourne, with 48,000 trade area, desperately needs doctor or doctor-dentist combination. Situation critical because of missile boom impact. Have large modern house (about 2000 sq. ft.) in shopping center. Four to six consultation rooms possible from three bedrooms and dining area. Built 1956. House suitable for office-residential; doctor-dentist combination, etc. Owner will rough-plumb changes. $250 per month double or office-residential; or $175 single until share-tenant secured. Property available on lease-option. New $1,500,000 hospital next year. Newcomb Realty Investments, Melbourne, Fla.

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POSITION WANTED: Board surgeon, native Floridian, University-Lahey trained, desires opening or association. Experienced in general surgery including neoplastic, head and neck, traumatic and abdominal. Florida license. Write 69-286, P.O. Box 2411, Jacksonville, Fla.

WANTED: Radiologist to associate with radiologist in hospital and office practice Southeast Florida. Florida license required. Must be eligible for isotope and cobalt therapy. Write 69-285, P.O. Box 2411, Jacksonville, Fla.

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Robins

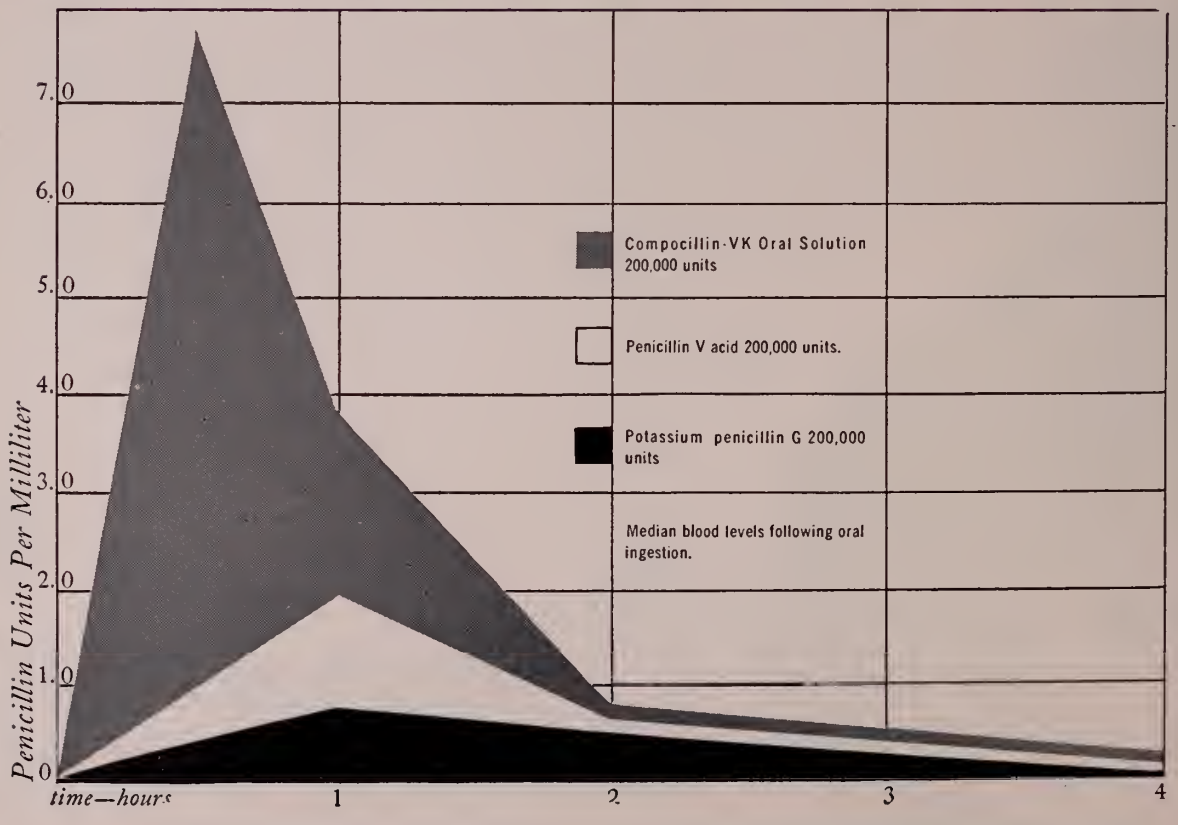
1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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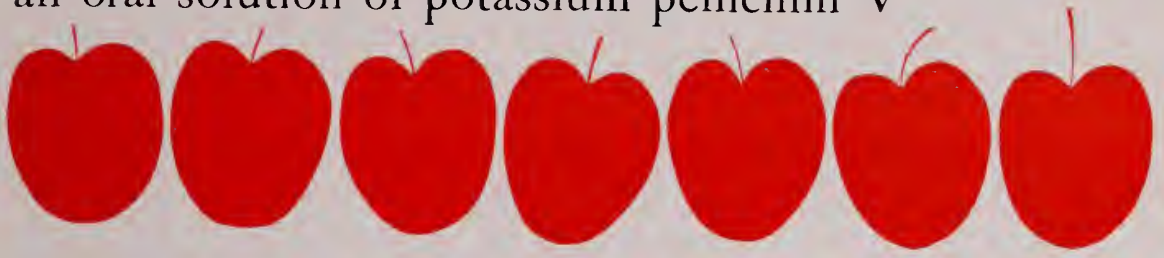

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Compocillin-VK Oral Solution 200,000 units
Penicillin V acid 200,000 units.
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Median blood levels following oral ingestion.



an oral solution of potassium penicillin V

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plus the higher blood levels of potassium penicillin V



POTASSIUM PENICILLIN V

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granules for oral solution

Now, for oral administration, Compocillin-VK Granules offer you a solution of potassium penicillin V. Developed by Abbott Laboratories, the granules are dry and easily reconstituted with water.

The clear, red solution has a fresh, cherry flavor, is taste-tested and is well-accepted by patients. And they'll get those high potassium penicillin V blood levels (note chart).

Compocillin-VK is indicated for all infections susceptible to oral penicillin therapy. Also, in treating recurring rheumatic fever and in managing rheumatic carditis. Compocillin-VK may be used in counteracting complications from severe viral attacks.

The initial recommended dose: In acute infections, the range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. For young children, the adult dose may be reduced in proportion to age and weight. For prophylactic use, 125 mg. (200,000 units) may be administered once or twice daily.

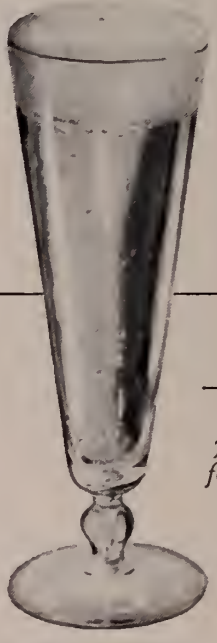
Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of the reconstituted solution represents 125 mg. (200,000 units) of potassium penicillin V. The dry granules stay stable under ordinary room temperatures. When reconstituted, the solution will remain potent for two weeks under refrigeration.

Abbott



A few suggestions on how to give your patient a diet he can "stick to"

Low-Purine Diet



—and a glass of beer, with your consent, for a morale-booster

• A tasty casserole of eggplant and tomato layered alternately with cottage cheese makes a satisfying entree. Fresh vegetables like string beans and beets may be served with a subtle dash of lemon juice. Oyster stew can be creamy without cream when milk is bolstered with dry skim milk powder.

Tuna-burgers nestle nicely in a nest of noodles. Ham 'n egg rolls come hot with scrambled eggs, cold with egg salad. Fruits and gelatins make excellent desserts and are easy to prepare. Corn or rice flakes do just as well.

And with a glass of beer* — at your discretion — your patient will find his diet interesting and ample without straying from your instructions.

*pH—4.3 (Average of American Beers)

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overgrowth
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TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

SUPPLIED:
CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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Combines Achromycin V with Nystatin

Achrostatin V combines Achromycin† V...the new rapid-acting oral form of Achromycin† Tetracycline...noted for its outstanding effectiveness against more than 50 different infections...and Nystatin...the antifungal specific. Achrostatin V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

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OBITUARIES

Oliver Clinton Brown

Dr. Oliver Clinton Brown of Fort Lauderdale died on March 10, 1958, in St. Vincent's Hospital, Birmingham, Ala., after a short illness. He was 69 years of age.

A native of Illinois, Dr. Brown was born in Cumberland County on Dec. 21, 1888. He received his elementary and high school education in Charleston, Ill., and was graduated from the Charleston High School in 1906. He attended the Hahnemann Medical College in Chicago and was awarded the degree of Doctor of Medicine by that institution in 1911. After completing an internship at the Hahnemann Medical College Hospital in 1912, he located in Shelbyville, Ill., and engaged in the general practice of medicine there until 1917 when he joined the United States Army as a first lieutenant. Upon discharge from military service in 1918, he specialized in ophthalmology and otolaryngology and practiced this specialty in Charleston, Ill., until he came to Florida in 1925 to reside in Fort Lauderdale.

Dr. Brown engaged in the active practice of his specialty in Fort Lauderdale for more than 32 years and was one of the city's five remaining pioneer physicians. He was a member of the staff of Holy Cross Hospital and of North Broward General Hospital. Especially interested in community health measures, he was active in organizing the County Health Unit in Broward County, in setting up a Mosquito Control District, in establishing the North Broward General Hospital, and in the community work that brought Holy Cross Hospital to Fort Lauderdale. A past president of the local Rotary Club, he had a perfect attendance record for 25 years and had served continuously on its Crippled Children's Committee. He was also a member of the Elks and Masonic lodges and the American Legion post. He was affiliated with the First Presbyterian Church of Fort Lauderdale.

Since 1926 Dr. Brown had been a member of the Broward County Medical Association and was a past president of that organization. He also held membership in the Florida Medical Association, the American Medical Association, the Florida Society of Ophthalmology and Otolaryngology and other societies of his specialty.

(Continued on page 344)

HYPERTENSION?



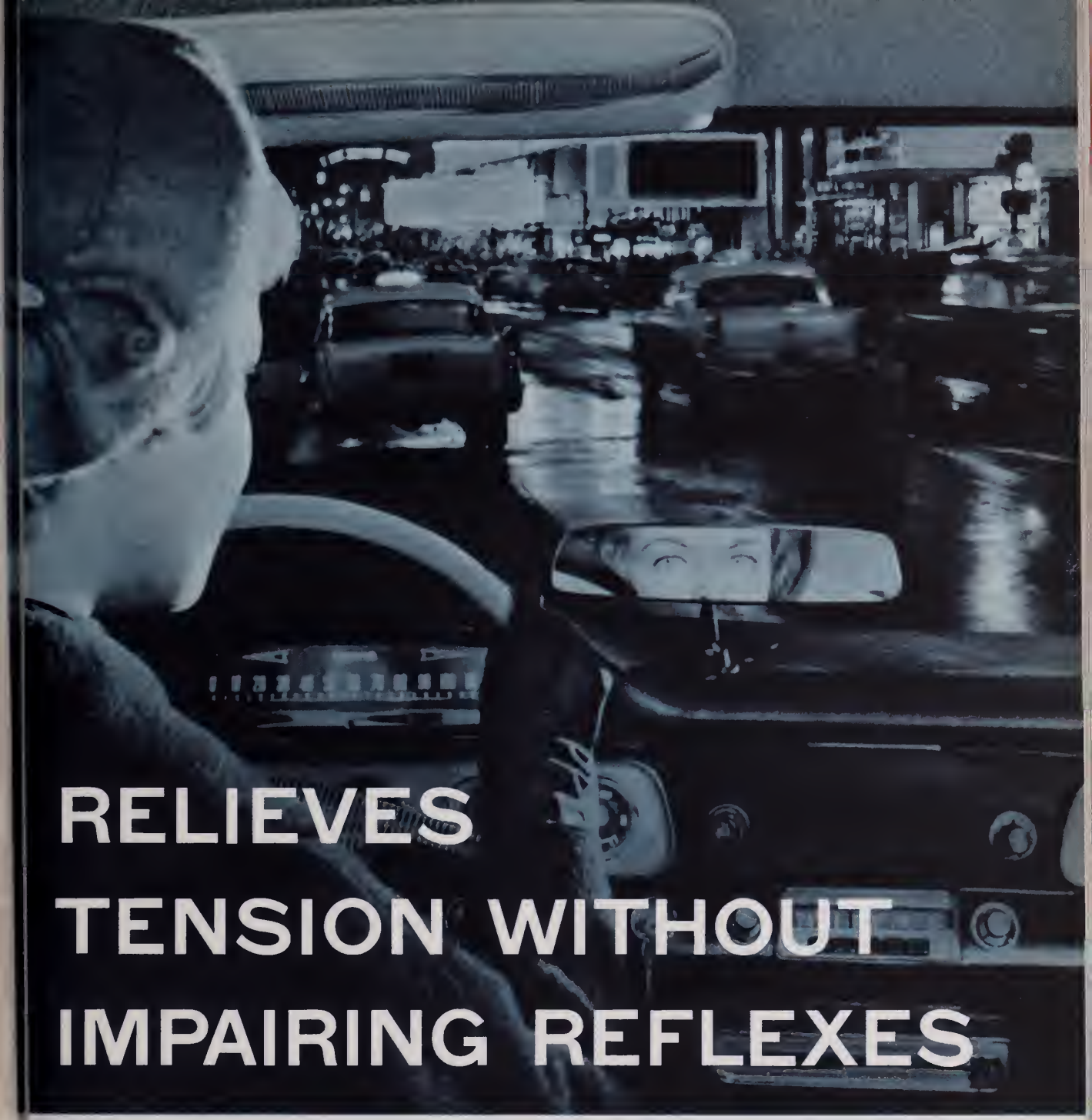
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Supplied:
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scored tablets,
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sugar-coated
tablets,
bottles of 50.

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

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triple benefits

first relieves apprehension, anxiety and irritability

second overcomes estrogen deficiency; relieves vasomotor and metabolic disturbances

third relaxes skeletal muscle; relieves low back pain, tension headache

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MILTOWN® TRANQUILIZER WITH MUSCLE-RELAXANT ACTION + CONJUGATED ESTROGENS (EQUINE) ORALLY ACTIVE ESTROGEN

Each tablet contains:

Miltown (meprobamate, Wallace) . . . 400 mg.
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Conjugated Estrogens (equine) . . . 0.4 mg.

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Literature and samples on request

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The physiologic depletion accompanying acute infectious and inflammatory conditions of the bowel makes replacement therapy the key to nutritional rehabilitation.

In addition to the loss of important electrolytes, such as potassium and sodium, large amounts of protein are lost in the fluid, blood and exudate from the bowel. In the acute state of such affections, utilization of what protein can be ingested is further affected by increased protein catabolism and by impairment of certain hepatic functions.

Dietary rehabilitation must be carried out within the framework of a diet restricted in fiber and in irritating substances. Foods allowed must be easily digested and appetizingly and attractively prepared to encourage eating.

Tender lean meats—finely ground in the initial diet and later served in a wide variety of appealing ways—can be an important source of the protein and minerals required by the convalescing patient.

Meat fits admirably into the requirements of the permitted diet not only because of its taste, digestibility, and physical characteristics, but also because of its contribution of high quality protein, the minerals potassium, iron, phosphorous, sodium, and magnesium, and all the known B vitamins.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

(Continued from page 342)

His widow, Mrs. Ethel Brown, survives him. Also surviving are a daughter, Peggy, the wife of Dr. Paul S. Woodall of Birmingham, and two grandchildren, Paul Oliver Woodall, a premedical student at Vanderbilt, and Alan Woodall; and a brother, R. W. Brown of Mattoon, Ill.

Julius Andrew Roth

Dr. Julius Andrew Roth of Delray Beach died suddenly at his home on March 19, 1958, following a heart attack. He was 51 years of age. Interment took place in La Crosse, Wis.

A native of La Crosse, where he was born in 1907, Dr. Roth received his medical degree from St. Louis University of Medicine in 1930. Since 1947 he had practiced general medicine with emphasis on obstetrics and gynecology in Delray Beach. A member of the staff of the Good Samaritan Hospital and of St. Mary's Hospital in West Palm Beach, locally he had been chosen staff gynecologist on the recently appointed staff of the new Bethesda Memorial Hospital. He also held membership in the Gulfstream Hospital Association. He was a member of the St. Vincent Ferrer Catholic Church and of the Rotary Club and Elks Lodge. In the United States Air Force Reserve he held the rank of Colonel.

Dr. Roth was a member of the Palm Beach County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association.

Surviving are two sons, David Roth of Delray Beach and Daniel Roth of Gainesville, a premedical student at the University of Florida. One sister, Miss Frances Roth of La Crosse, also survives.

William Benjamin Moon

Dr. William Benjamin Moon of Crystal River died at his home on March 20, 1958. He was 87 years of age.

Born in Valeene, Ind., on Aug. 15, 1870, Dr. Moon studied medicine in Louisville and Chicago. He received his medical degree from the Hospital College of Medicine in Louisville in 1897. He then practiced for some years in Illinois and Kansas before locating in Crystal River in 1911.

During World War I, Dr. Moon served in the medical corps of the United States Army with

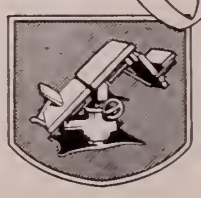


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and he solved their problems with a nutrition product from

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the rank of major. Except for that period of military service he engaged in the general practice of medicine in Citrus County from 1911 until a few years ago when ill health forced his retirement. Shortly after he resumed his practice in Crystal River after the war, he suffered an injury in an automobile accident which necessitated the use of crutches for five years and for three years of that time he was lifted into and out of his car as he continued his work as a practicing physician. An operation for a crushed hip socket eventually enabled him to discard his crutches.

Dr. Moon enjoyed an active and varied career. He served as a state senator for three terms, serving first in 1929 and again in 1945 and 1947. As a legislator, he earned credit for legislation leading to the use of surplus war equipment for clinics and hospitals. He operated a drugstore and was a registered pharmacist. He also liquidated three banks. He was a Mason, a Legionnaire and an elder in the Crystal River Presbyterian Church.

Dr. Moon was a member of the Pasco-Hernando-Citrus County Medical Society. He also held membership in the Florida Medical Association and the American Medical Association.

He is survived by his widow, Mrs Grace Elinore Moon, of Crystal River; a daughter, Mrs. Benita White, of Miami; a brother, Perry Moon, of Hardensburg, Ind.; five grandchildren and six great grandchildren.

James Stokes Smith

Dr. James Stokes Smith of Miami died on May 17, 1958, in the Cleveland Clinic, Cleveland, Ohio, after a long illness of congestive heart failure and hypertension. He was 51 years of age.

Born in Ruskin, Tenn., on April 1, 1907, Dr. Smith was educated in his native state. He attended Battleground Academy in Franklin and received his professional training in Nashville. In 1930 he was awarded the degree of Doctor of Medicine by Vanderbilt University School of Medicine.

Dr. Smith had been a resident of Miami for 20 years. He practiced medicine and surgery there from 1936 to 1941, when he was called to active duty with the Army Medical Corps. Serving in the Philippine Islands, he became a mem-

(Continued on page 354)

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CORONARY VASODILATOR

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ORAL (tablet swallowed whole)
for dependable prophylaxis
SUBLINGUAL-ORAL
for immediate and sustained relief
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NITROGLYCERIN—
0.4 mg. (1/150 grain)—acts quickly

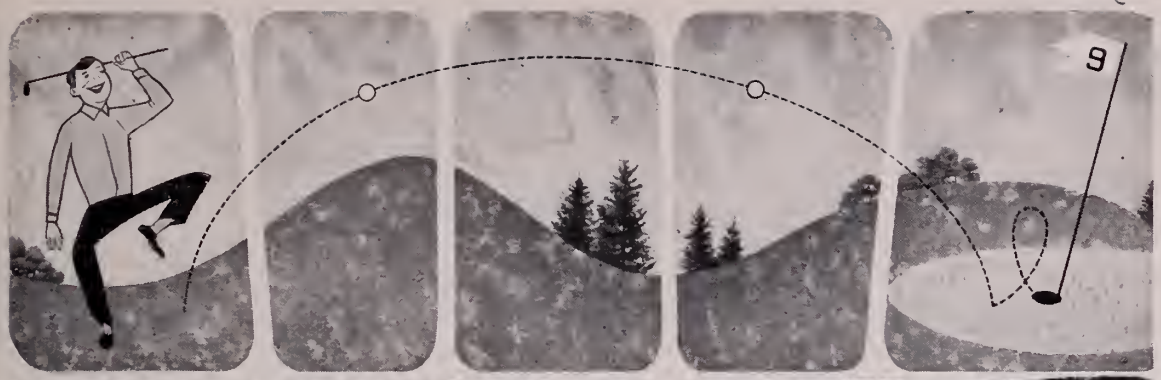
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PENTAERYTHRITOL TETRANITRATE—
15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet.
Average prophylactic dose:
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Therapeutic dose:
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Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
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References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. II: 1 (June) 1958 *Reg. U. S. Pat. Off.



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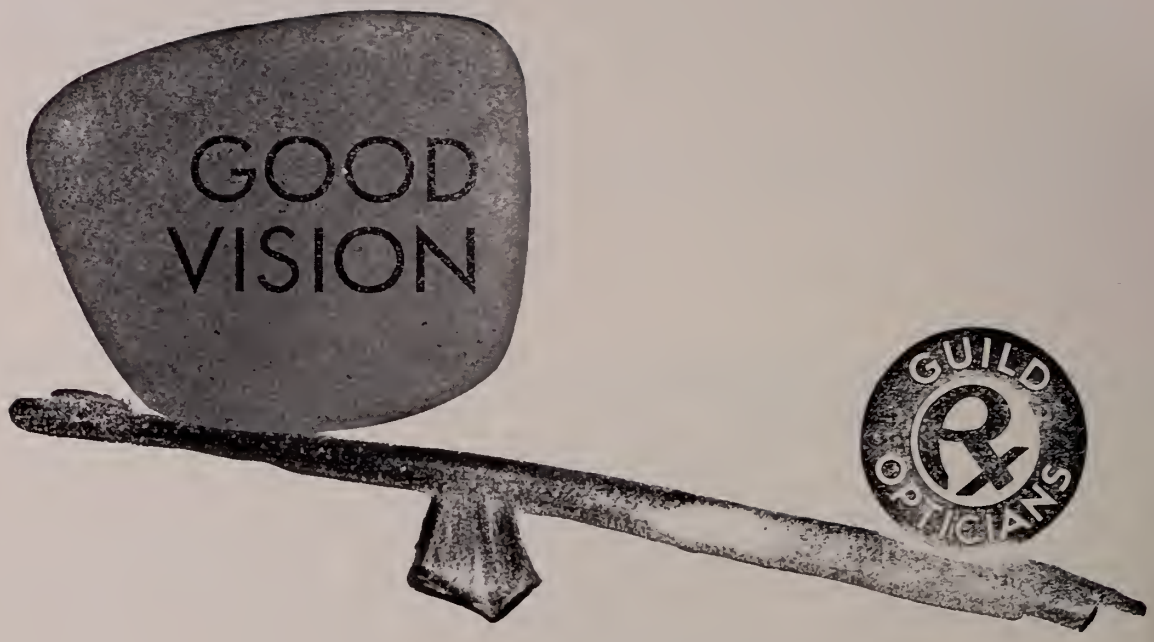
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Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."





In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

the effectiveness of 'DIURIL'
(CHLOROTHIAZIDE)
in
Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

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Smooth, more trouble-free management of hypertension with 'DIURIL'

(Continued from page 346)

ber of the infamous Bataan Death March and was imprisoned by the Japanese for more than four years. During his imprisonment he suffered from severe beriberi and was struck by a Japanese guard, receiving an injury which eventually led to the operation at the Cleveland Clinic which cost him his life. The combination of injury and disease resulted in a continuous struggle with ill health and during the last eight years periods of hospitalization at Vanderbilt University Hospital, the Mayo Clinic and the Cleveland Clinic. He was awarded the Purple Heart with an oak leaf cluster and the Legion of Merit, the latter for his work in treating the wounded during the Battle of Bataan, January 25 through April 9, 1942. He was separated from the service with the rank of lieutenant colonel in the National Guard.

Returning to Miami, Dr. Smith resumed the practice of obstetrics and gynecology in Allapattah and continued to practice there until he left for Cleveland on May 7. Locally, he was on the staff of North Shore Hospital and was a member of the Allapattah Methodist Church, the Allapattah Lions Club and the Knights of Pythias.

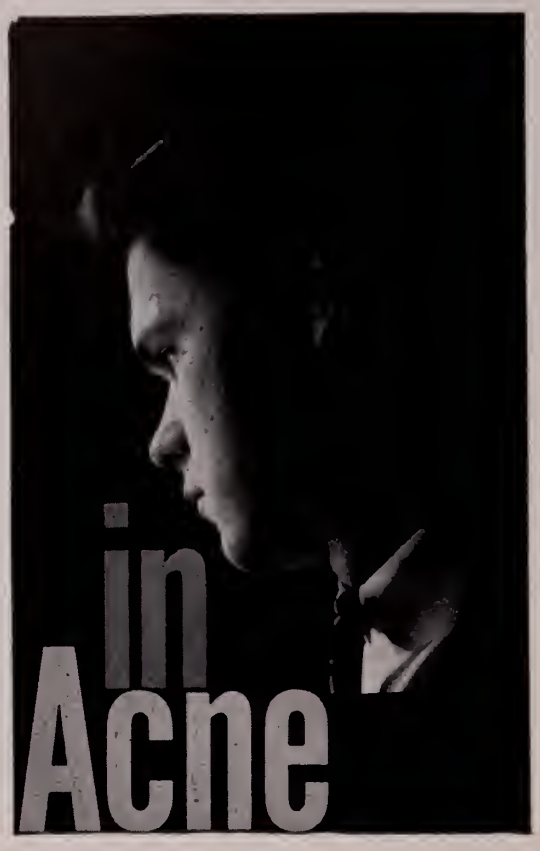
Dr. Smith was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He also held membership in the American Academy of General Practice.

Surviving are the widow, Mrs. Muriel Smith, of Miami, and a daughter, Miss Audrey Smith, a student at Vanderbilt University. Other survivors include two sisters, Mrs. W. F. Cody, of Homestead, and Mrs. S. C. Aviatt, of Tampa; two brothers, H. M. Smith, of Minneapolis, Minn., and Elmer T. Smith, of Nashville, Tenn.; and his stepmother, Mrs. J. D. Smith, of Franklin, Tenn.

Harry Moses

Dr. Harry Moses of Palm Beach died in a local hospital on March 20, 1958, after a long illness. He was 75 years of age. Interment took place at St. Matthews, S. C.

Born in Montgomery County, Georgia, in 1882, Dr. Moses was graduated from Mercer University, which later honored him with an award for 50 years of loyalty, service, culture and citizenship. In 1908, he received the degree of Doctor of Medicine from the University of Virginia De-



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pHisoHex maintains normal skin pH, cleans and degerms better than soap. In acne, it removes oil and virtually all skin bacteria *without scrubbing.*

For best results—four to six washings a day with pHisoHex will keep the acne area "surgically" clean.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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partment of Medicine, where he was a member of the Raven Club. After completing an internship at the University of Virginia Hospital, he served as house surgeon at Bellevue Hospital in New York City. He held fellowships in allergy and geriatrics.

Dr. Moses was a brilliant surgeon and chief of various services in the hospitals of Macon, Ga., where he practiced until he located in Palm Beach 18 years ago. Locally, he was a member of the staffs of the Good Samaritan and St. Mary's hospitals. For 12 years, until his retirement two years ago because of ill health, he was house physician at the Breakers. He was an Episcopalian and a member of the Society of the Four Arts and the Palm Beach Round Table. A thirty-second degree Mason and a Shriner, he was a charter member of the Rotary Club at Macon.

Since 1940, Dr. Moses had been a member of the Palm Beach County Medical Society and the Florida Medical Association. He was also a member of the American Medical Association and a fellow of the American College of Surgeons and the International College of Surgeons.

Dr. Moses is survived by his widow.

Robert York Wheelihan

Dr. Robert York Wheelihan of Riviera Beach died on July 2, 1958, after a short illness. He was 55 years of age.

Dr. Wheelihan was born at Everett, Wash., on Aug. 15, 1903. He received his early schooling in Duluth, Minn., and his academic training at the University of Wisconsin, where he was awarded the B.S. degree. For his professional training he attended Northwestern University Medical School, earning the M.D. degree in 1928. He served internships in Milwaukee Hospital and the Milwaukee Children's Hospital in Milwaukee, Wis., and at the Chicago Children's Memorial Hospital in Chicago.

After practicing medicine in Elm Grove, Wis., for 20 years, Dr. Wheelihan located in Riviera Beach in 1950. Locally, he was vice president of the staff of St. Mary's Hospital and was active in civic affairs in the area and in church work. He was a member of the Riviera Beach Chamber of Commerce, a charter member of the Kiwanis Club and a director of the Riviera Beach Savings and Loan Association. A communicant of St.

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'Benemid' is firmly established as an *effective* and exceptionally ***safe*** uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

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Francis of Assisi Catholic Church, he was president of the Holy Name Society of that church and as a member of the St. Vincent de Paul Society there he held the honorary title of "Fourth Order."

Dr. Wheelihan was a member of the Milwaukee Medical Society while practicing in Wisconsin. In Florida, he became a member of the Palm Beach County Medical Society and for a time served as its secretary. He also held membership in the Florida Medical Association, the American Medical Association and the Southern Medical Association. He was a charter member of the American Academy of General Practice.

Surviving are the widow, Mrs. Marion Soerens Wheelihan, of Palm Beach Shores; three sons, Richard S. Wheelihan, of Lake Worth, and Charles Robert and Robert James Wheelihan, of Palm Beach Shores; and three daughters, Mrs. Marion Geiger, of West Palm Beach, and Miss Kathryn Marie and Miss Margaret Susan Wheelihan, of Palm Beach Shores. Other survivors include his father, W. P. Wheelihan, of Chicago, an aunt, Miss Margaret Koen, of Palm Beach Shores, and a niece, Mrs. Ann Kringel, of Riviera Beach.

Manen Quincy Burns

Dr. Manen Quincy Burns of Blountstown died on June 15, 1958, at Frasier-Ellis Hospital in Dothan, Ala., following a heart attack. He was 69 years of age.

A native of Florida, Dr. Burns was born at Graceville in 1888. He received his medical training in Atlanta, where he was awarded the degree of Doctor of Medicine in 1913 by the Southern College of Medicine and Surgery, later Emory University School of Medicine.

In 1921, Dr. Burns entered the general practice of medicine in Blountstown and had continued to practice there since that time. He was a member of the Methodist Church and was active in the affairs of the community for nearly four decades.

Dr. Burns was a member of the Jackson-Calhoun County Medical Society. For more than 30 years he had held membership in the Florida Medical Association.

Surviving are the widow, Mrs. Annie Belle Coley Burns, of Blountstown, and one daughter, Mrs. Emma Elizabeth Clary, of Albuquerque, N. M. Three grandchildren also survive.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

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For patients susceptible to monilial superinfection.

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FERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 2 (Jan.) 1958. 3. Walch, E.: Dent. Med. Wschr. (April) 1956. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 ne) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and edley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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running noses and open stuffed noses orally



Relief in minutes....lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

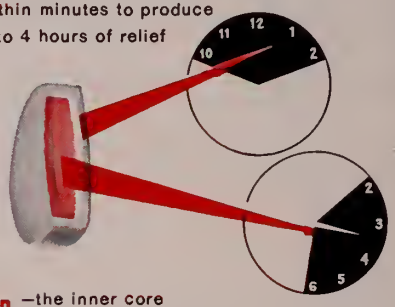
Each timed-release TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, mid-afternoon, and in the evening, if needed. To be swallowed whole to preserve the timed-release feature.

Each timed-release tablet keeps the nasal passages clear for 6 to 8 hours— provides "around-the-clock" freedom from congestion on just three tablets a day

first —the outer layer dissolves within minutes to produce 3 to 4 hours of relief



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Convention Highlights from San Francisco

Formal opening of the Thirty-Fifth Annual Convention of the Woman's Auxiliary to the American Medical Association was held June 24 at the Fairmont Hotel, San Francisco.

The address of welcome was given by Mrs. Leonard D. Offeld, immediate past president of the Woman's Auxiliary to the California Medical Association, and Mrs. Arthur E. Brown, immediate past president of the Woman's Auxiliary to the Mississippi State Medical Association, presented the response. California cordiality and hospitality reigned supreme throughout the entire Convention.

Guest luncheon speaker for the first day was Richard H. McFeeley, principal of the George School in Bucks County, Pa. The afternoon meeting featured a speech by W. W. Hetheringtor publisher, and James Liston, editor, on "Today' Health Future Plans."

Convention visitors were delighted with an entertaining and useful guide to San Francisco distributed at the registration desks during the annual meeting. This was published by Medical News and written by a San Francisco newspaperman. It helped the visitor choose his own way of enjoyment — at suitable cost.

Not forgotten in Convention planning were the teenage visitors. The Woman's Auxiliary sponsored "Teen Fun" for conventioners' sons and daughters in cooperation with the California Medical Association. While parents attended scientific and business sessions, their teenagers were socially engaged. Swimming, a tour of Chinatown, a coke party, and a film were part of the activities. What a wonderful idea!

Another outstanding feature was a special showing of "Helping Hands for Julie," a film on career opportunities in medicine and health presented as part of the Convention program. This is a 30 minute, black and white sound film designed to attract students into health and medical

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careers by dramatizing their opportunities. The film is available to high schools and community organizations on loan without cost through Associated Films, Inc., 347 Madison Ave., New York 17, N. Y. It is hoped that we will avail ourselves of the opportunity to use this film in one of the projects of the year.

The Florida delegation did themselves proud with 100 per cent attendance. There were excellent and inspiring speakers at all sessions, and nine round table discussions were found to be very helpful.

Dr. George F. Lull of Chicago, President of the American Medical Education Foundation, received the Auxiliary's 1958 contribution, a total of $126,000. What a wonderful amount of good we all do when our dollars are combined!

Final highlight was the installation of new officers. They are: President, Mrs. Arthur Underwood, Washington (state); President-Elect, Mrs. Frank Gastineau, Indiana; 1st Vice President, Mrs. Richard Stover, Florida; 2nd Vice President, Mrs. William MacKersie, Michigan; 3rd Vice President, Mrs. Paul Rauschenbach, New Jersey; 4th Vice President, Mrs. William Thuss, Alabama; 5th Vice President, Mrs. Matthew Horner, California; Constitutional Secretary, Mrs. C. R. Pearson, Wisconsin; Treasurer, Mrs. Harlon English, Illinois; Directors, Mrs. William Evans, Ohio, and Mrs. M. A. Gold, Montana.

Florida is indeed proud of our own Ann Stover. She will do an excellent job as she has in so many other responsible positions which she has already held. Our congratulations to her and to all the other Florida delegates at this Thirty-Fifth Annual Convention.

Mrs. Albert F. Stratton Jr.

BOOKS RECEIVED

Clinical Obstetrics and Gynecology: Volume 1, Number 1, Medical Problems in Pregnancy, edited by Curtis J. Lund, M.D.; and **Management of Endocrine Problems,** edited by Allan C. Barnes, M.D. Pp. 288. Price, $18.00 by subscription for four consecutive numbers. New York, Paul B. Hoeber, Inc., 1958.

The appearance of this March 1958 first volume of a new quarterly book series, entitled Clinical Obstetrics and Gynecology, marks the launching of a completely new kind of literature in this area of clinical medicine. This series is planned to offer a central, continuing source of information on the procedures used by experts at leading centers in the actual care of patients, filling a gap between the original research reported in journals and the comprehensive coverage of textbooks. It will appear serially in March, June, September and December and in time will likely become the equivalent of an encyclopedia of clinical practice in obstetrics and gynecology. To facilitate the continuing reference use of the volumes,

(Continued on page 370)

Doctors, too,  *like "Premarin"*

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen.

Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms before the menopause and even after, "Premarin" takes care of that, too.

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In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

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Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

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Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



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MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .



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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

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(Continued from page 366)

therefore, a cumulative index will be included in each issue through the year.

From the suggestions collected from both specialists and general practitioners all over the country, the basic structure as seen in this first volume was developed—two symposiums per issue, one on a subject of clinical interest in obstetrics and one in gynecology. Each is planned and supervised by a Guest Editor, selected not only for his own original work but also for his teaching and clinical experience. Each contributor, chosen for his special clinical knowledge of a particular subject, has been asked to describe clearly and directly just how he handles specific clinical problems in his assigned area. In this initial volume of the series the Symposium on Medical Problems in Pregnancy seeks to present the obstetric point of view on the common medical complications which are so important in the morbidity and mortality of pregnancy. The Symposium on Management of Endocrine Problems covers diagnostic aids and problems related to menstrual function, to pregnancy and the puerperium, and to growth and sexual development.

A Primer on Common Functional Disorders. By Jack W. Fleming, M.D. Pp. 174. Price, $5.00. Boston, Little, Brown and Company, 1958.

This primer offers guidance to all doctors and students who are not psychiatrists but who are called upon to deal with psychogenic disorders. The author is a member of the Florida Medical Association and heads the Department of Internal Medicine of The Medical Center Clinic in Pensacola. An internist who has seen the need for a constructive program of management for these disorders, he presents in easily understandable terms the current concepts of psychogenic diagnosis, concise pictures of the disorders most frequently encountered in everyday practice, approaches to psychotherapy, and finally, how all of these factors can be integrated into realistic programs of patient management.

A positive approach to the diagnosis of psychogenic and nonpsychogenic functional disorders is presented in detail in the first chapter. In the second chapter the neurologic and endocrine factors which are associated with psychophysiologic disorders are described, and the concept of protective reaction patterns is elaborated. A practical approach to the management of patients with functional disorders through the integration of standard medical history taking, physical examinations, and technics of psychotherapy is elucidated in chapter three. A concise outline of this dynamic approach is presented in chart form. Most of the remaining chapters describe the various functional disorder syndromes as viewed by the physician who is not a psychiatrist. Medical treatment and psychotherapy are integrated, and emphasis is placed on the importance of the physician-patient relationship as a therapeutic entity at all levels of therapy. There are cartoon illustrations in each chapter that can be used by the physician to explain functional disorders to his patients.

"Perhaps the foremost aim of this primer," Dr. Fleming declared in the Preface, "is to encourage fellow nonpsychiatrist physicians and students to take a broader, more relaxed attitude toward pschogenic illness."

Signs, Symptoms and Treatment of Certain Acute Intoxications. By William B. Deichmann, Ph.D., and Horace W. Gerarde, M.D., Ph.D. Ed. 2. Pp. 154. Price, $3.75. Springfield, Ill., Charles C. Thomas, Publisher, 1958.

This condensed synopsis on poisons was originally designed for the use of interns and residents on emergency service at the Jackson Memorial Hospital in Miami, and it was anticipated that it would prove useful to the



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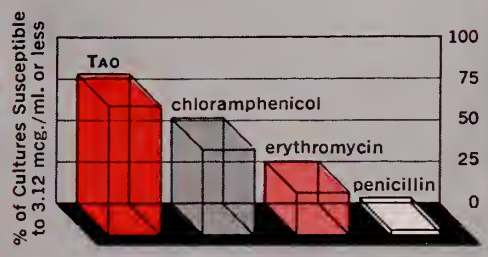
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CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
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Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



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REACTIONS:

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Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
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There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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general practitioner as a ready source of information regarding the nature of many insecticides marketed under a trade name. The enthusiastic reception of the first edition and the realization that publications in this dynamic field have a short "half-time" promoted the preparation of this second edition.

This small volume listing signs and symptoms of certain acute intoxications and making recommendations for treatment retains the convenient size and format of the first edition. The number of chemicals has been increased, new sections have been added, and others expanded. A brief section on First Aid advice which physicians can give on the telephone to frantic individuals reporting a case of acute intoxication has been added. Also included is a section on Artificial Respiration for adults, infants, and young children. Chemicals are again arranged alphabetically and numerically for simplicity and rapidity in finding them. The book is not intended to be a pharmacology text or encyclopedic in its coverage. Emphasis is placed on brevity and accuracy, and as in the first edition, no attempt is made to list well known chemicals, but to include instead those compounds which have been described in the most recent literature in medicine, pharmacology and toxicology. Original literature sources are given for the reader who desires more complete information. In all, some 400 new entries have been added without making the text too unwieldy for a pocket reference.

Dr. William B. Deichmann, Professor and Chairman of the Department of Pharmacology of the University of Miami School of Medicine, has had the cooperation of Dr. Horace W. Gerarde, Head Toxicologist of the Esso Research and Engineering Company, Medical Research Division, Linden, N. J., in the preparation of this handy little volume. The book is dedicated to Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine.

Our Nuclear Adventure. *Its Possibilities and Perils.* By D. G. Arnott. Pp. 170. Price, $6.00. New York, Philosophical Library, 1958.

The primary object of this book is to provide sufficient information for the ordinary person to take an intelligent interest in the technical developments of nuclear power, and in the big political and social issues which accompany it. This lucid assessment of the potentialities and hazards inherent in the harnessing of nuclear energy avoids sensationalism and marshals the available evidence of the power for good—or evil—of man's most important scientific advance. The author has worked with radioactive materials for nearly two decades and since 1946 has served on the Atomic Sciences Committee of the Association of Scientific Workers as Chairman or Secretary.

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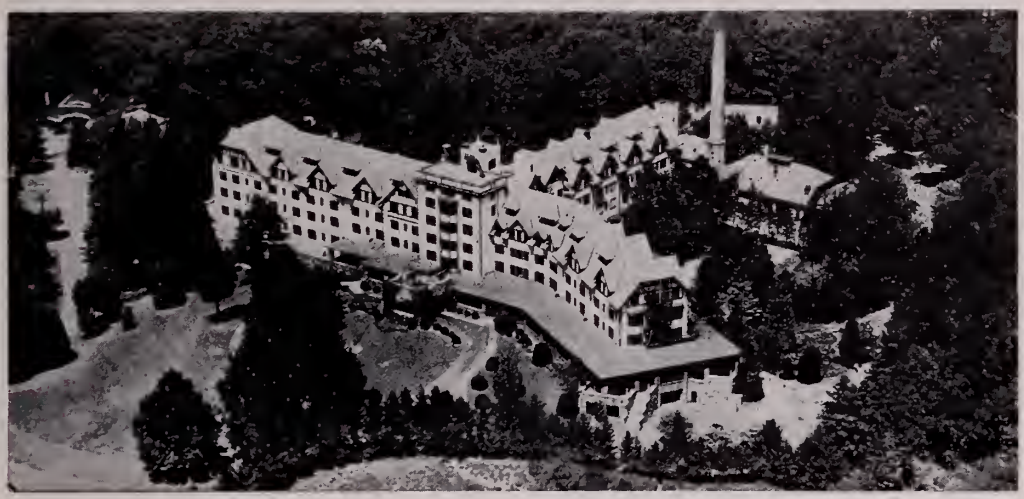
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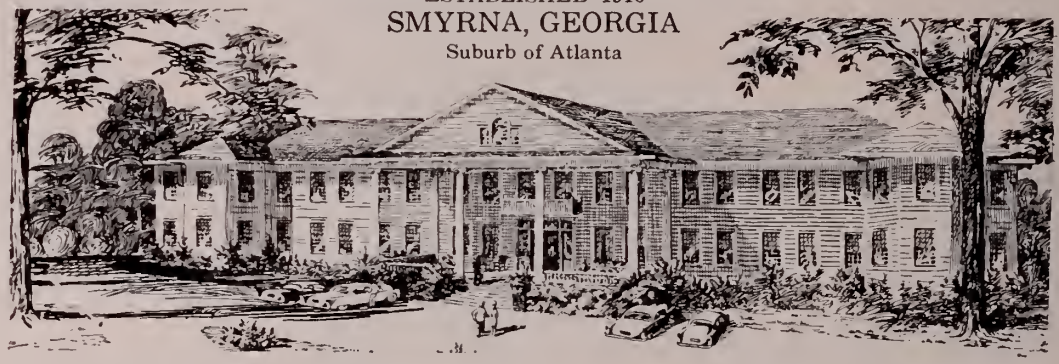
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	2nd Tues.	31
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	1st Tues.	59
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	2nd Tues.	210
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	3rd Wed.	13
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	898
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	27
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	352
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	113
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	234
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	14
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	33
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	80
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	7
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	33
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	35
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	15
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	9
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	224
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Herman Baxt, W. Palm Beach	4th Mon.	167
Pasco-Hernando-Citrus	S. Carnes Harvard, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	288
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	127
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	13
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Reuben J. Plant Jr., St. Augustine	3rd Tues.	22
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	83
Seminole	Daniel H. Mathers, Sanford	Vann Parker, Sanford	2nd Tues.	17
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	7
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	94
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	30
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		6

* *Supervise and aid until organized separately.*

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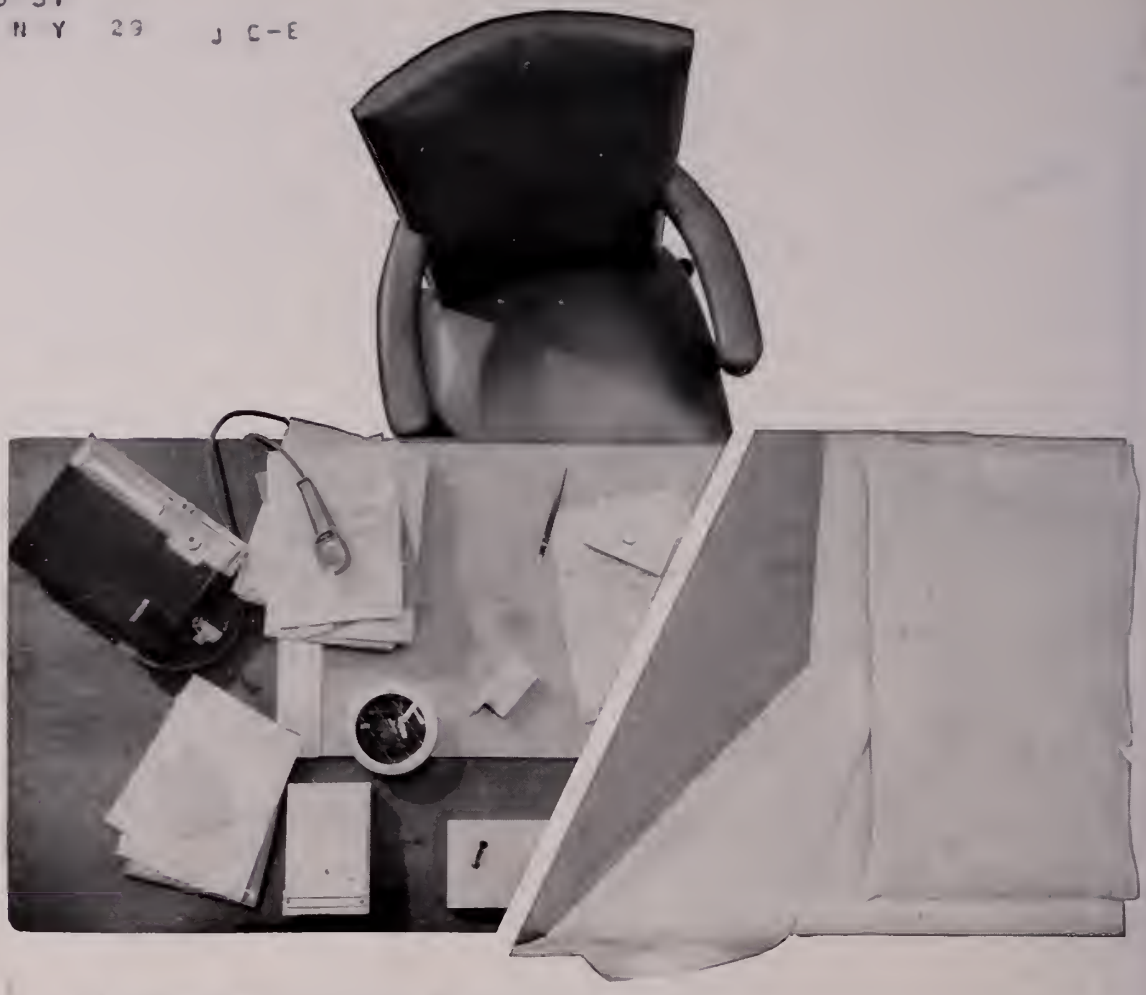


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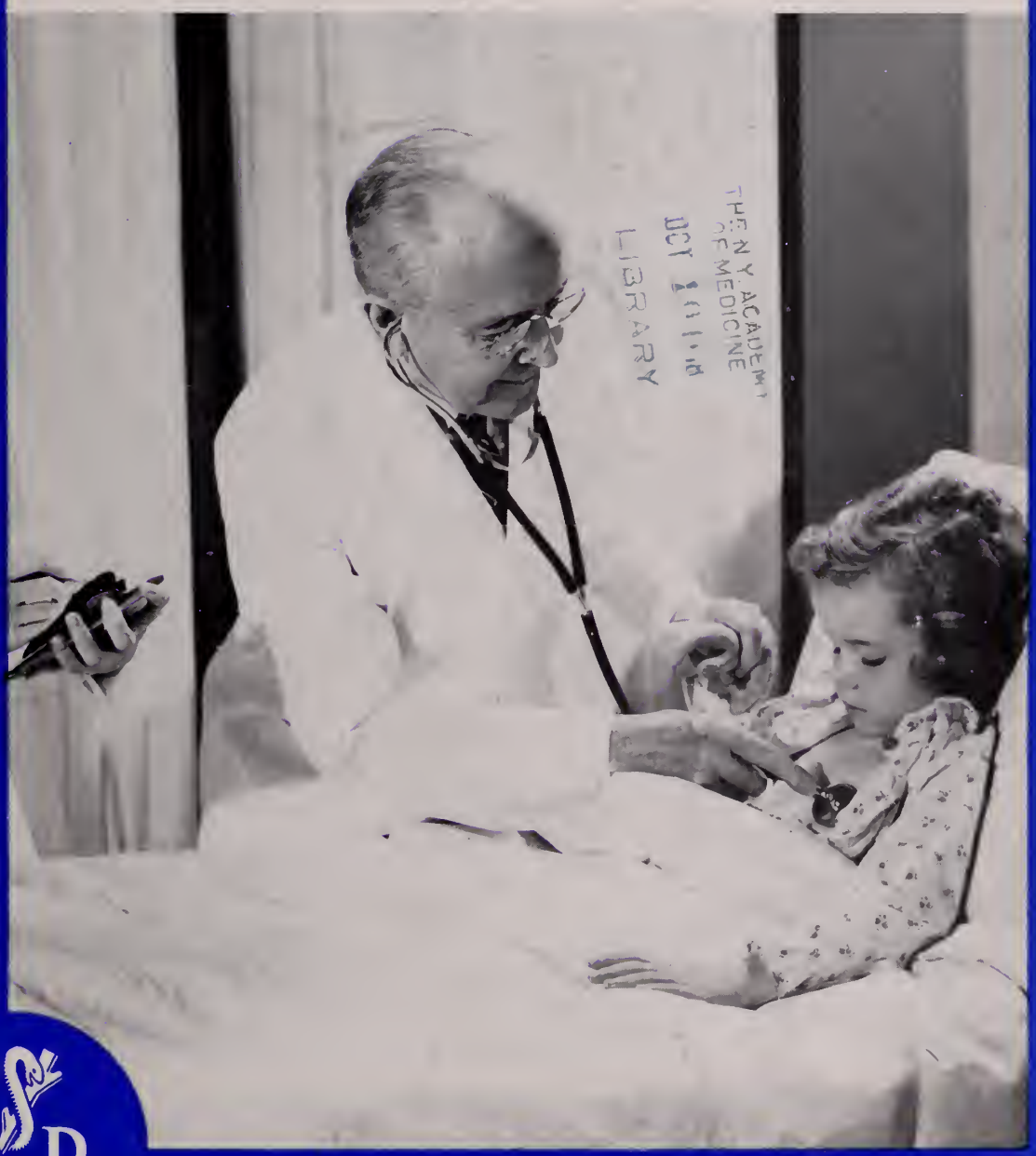
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in amenorrhea . . .

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REFERENCES: (1) Greenblatt, R. H., & Jungck, E. C.: *J.A.M.A.* 166:1461 (Mar. 22) 1958. (2) Hert Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956.

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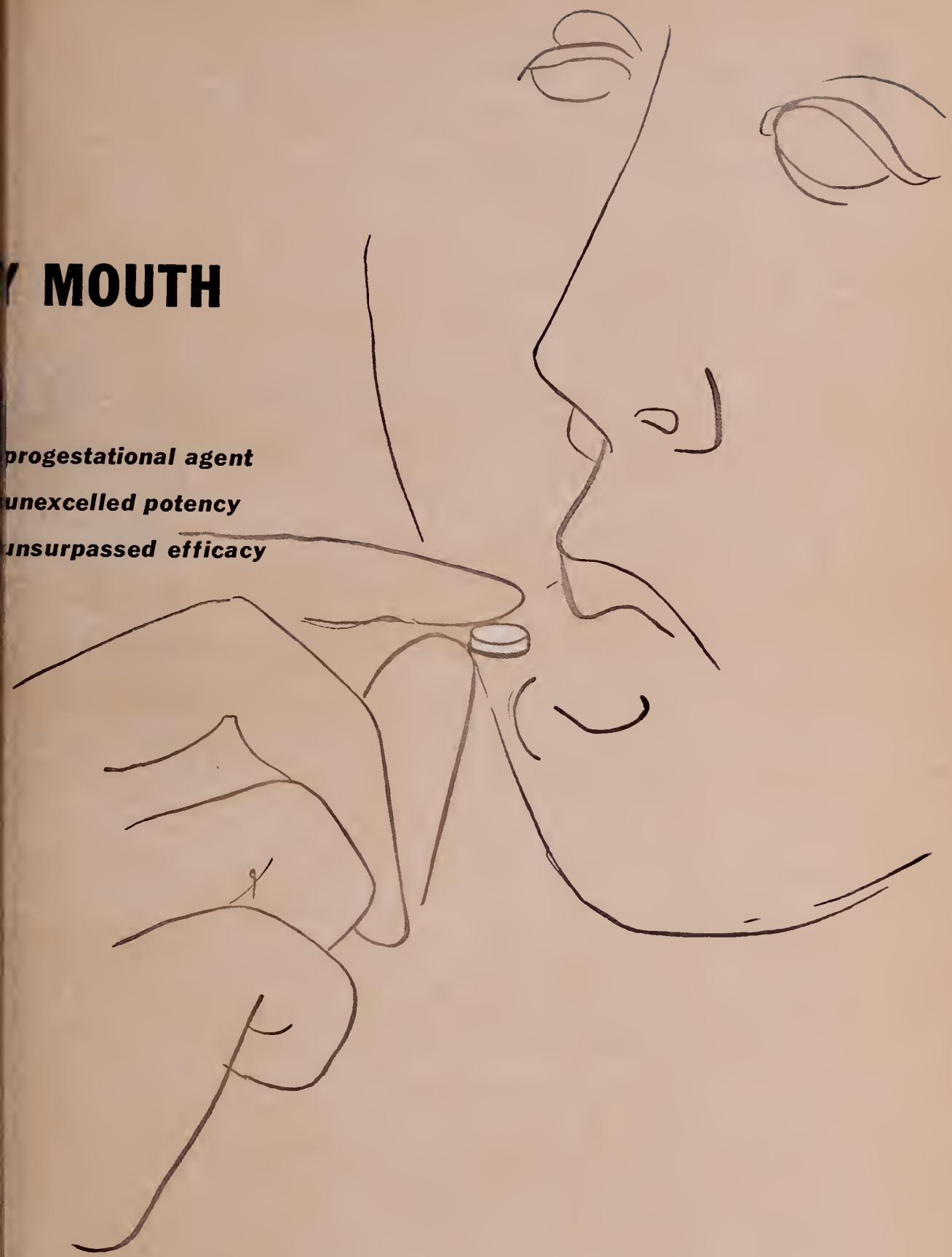
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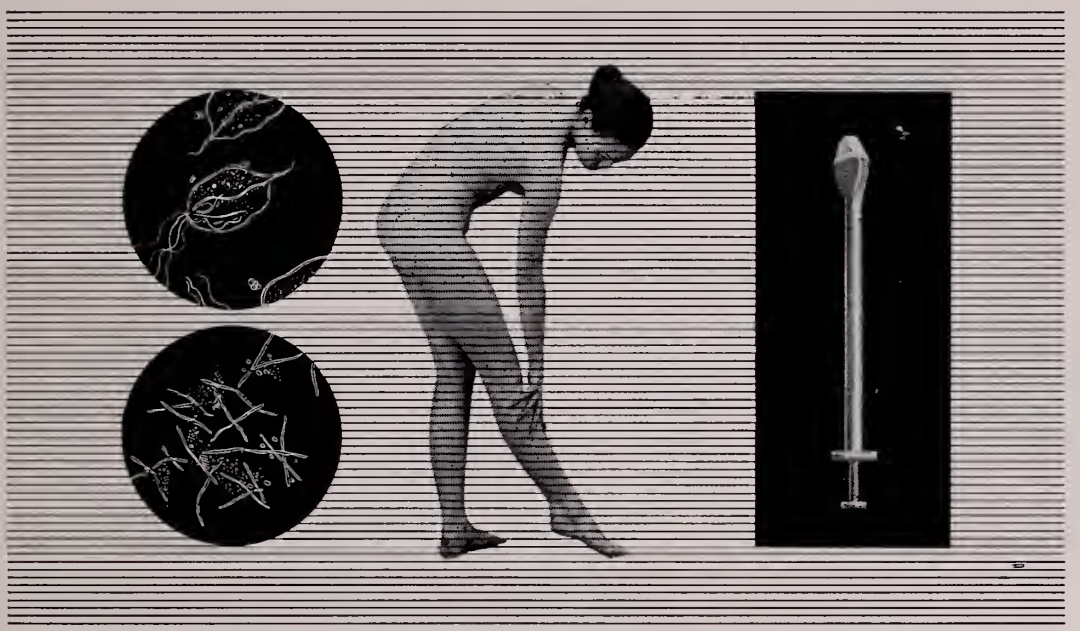
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1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157:*126 (Jan. 8) 1955.

2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25:*182 (Feb.) 1956.

3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51:*1494 (June 15) 1956.

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- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
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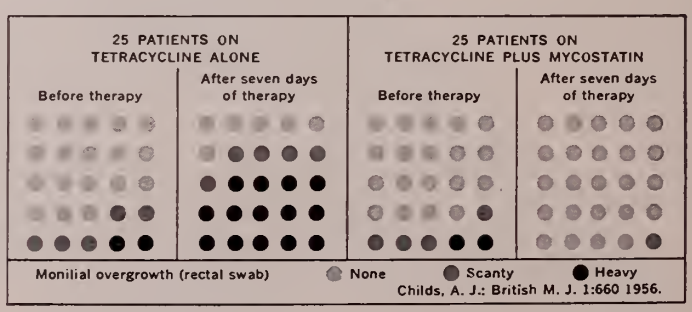
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Childs, A. J.: British M. J. 1:660 1956.

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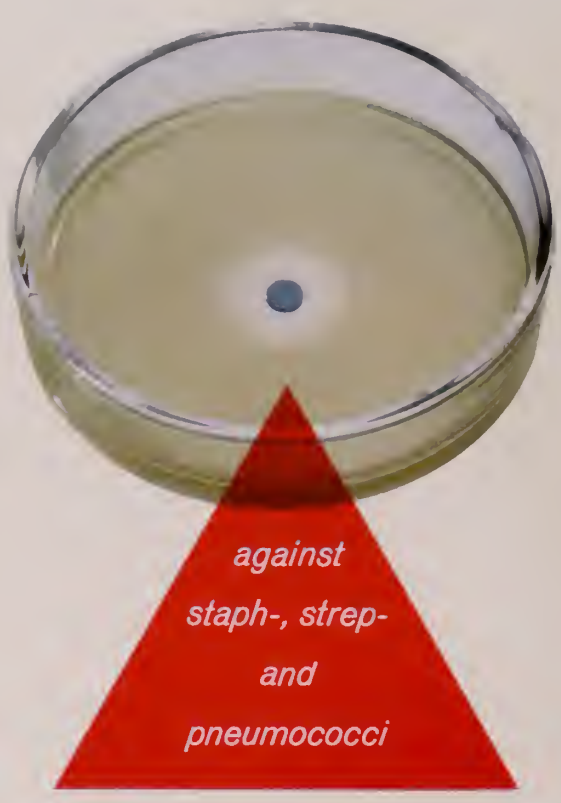
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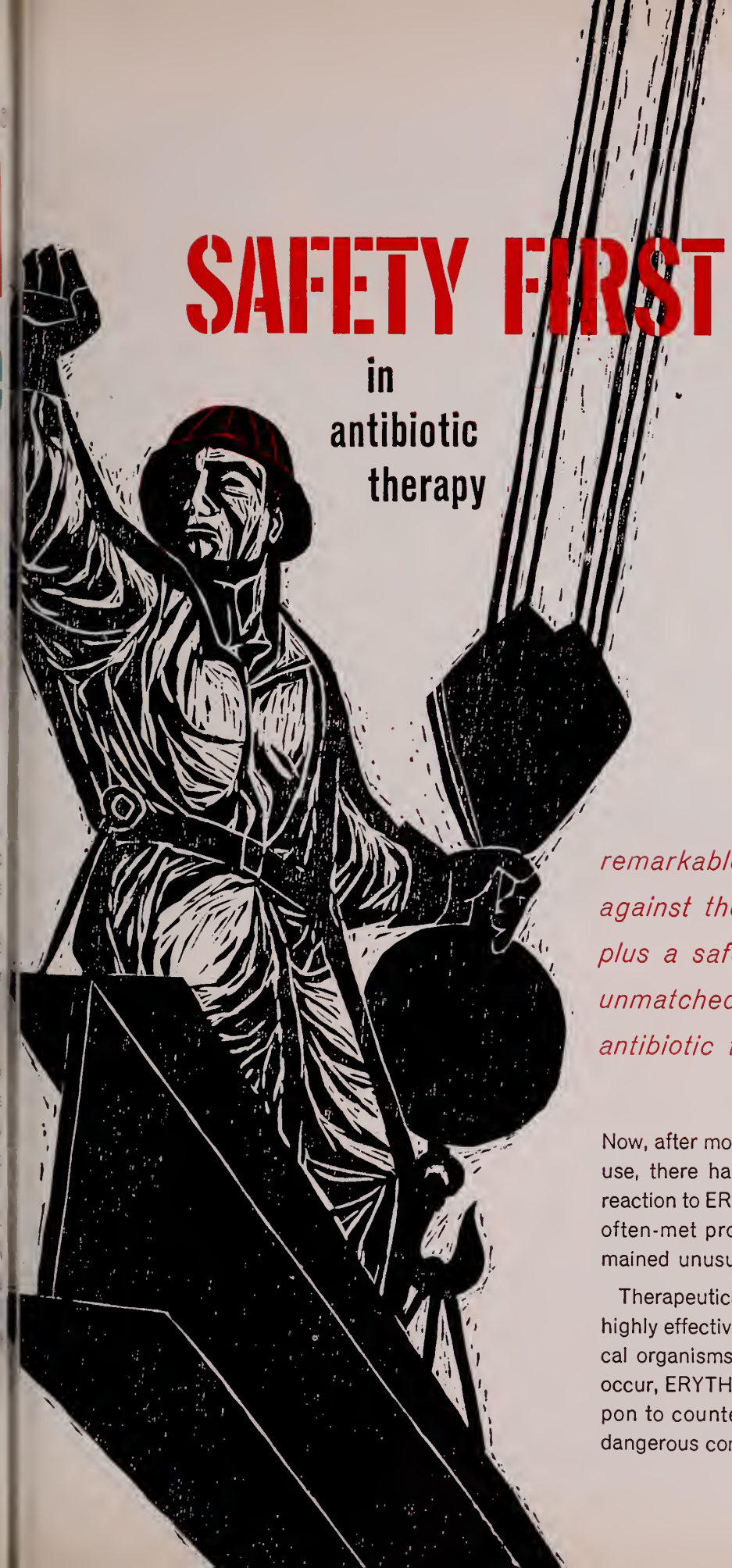
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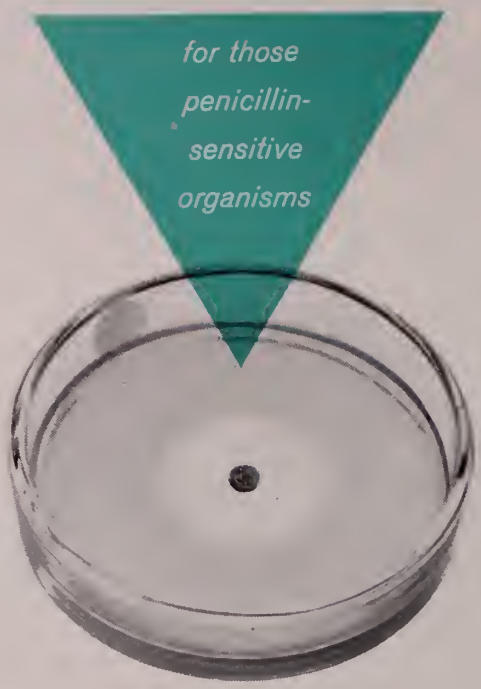
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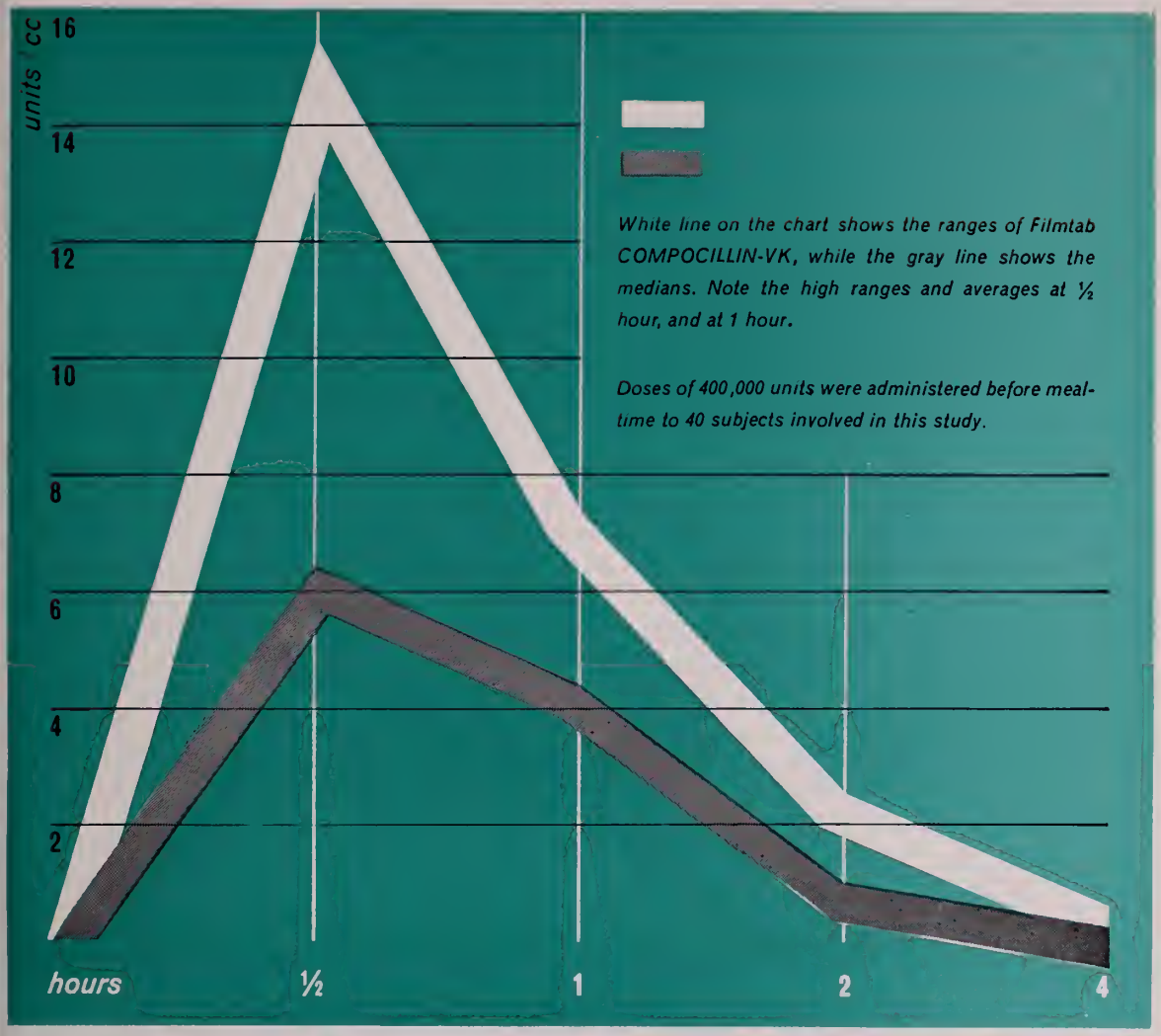
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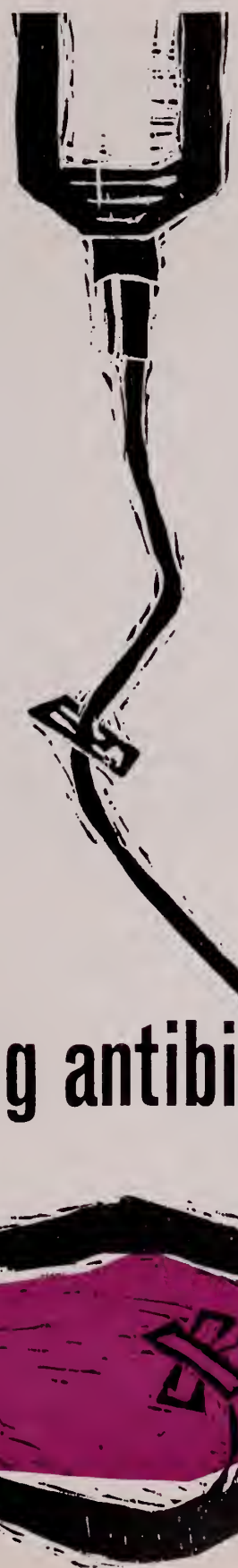
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1. Antibiotics Annual, 1956-'57, p. 706.
2. Antibiotics Annual, 1957-'58, p. 180-7.



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(1) Marangoni, B. A.: Am. Pract. & Digest Treat. *8*:1959, 1957.

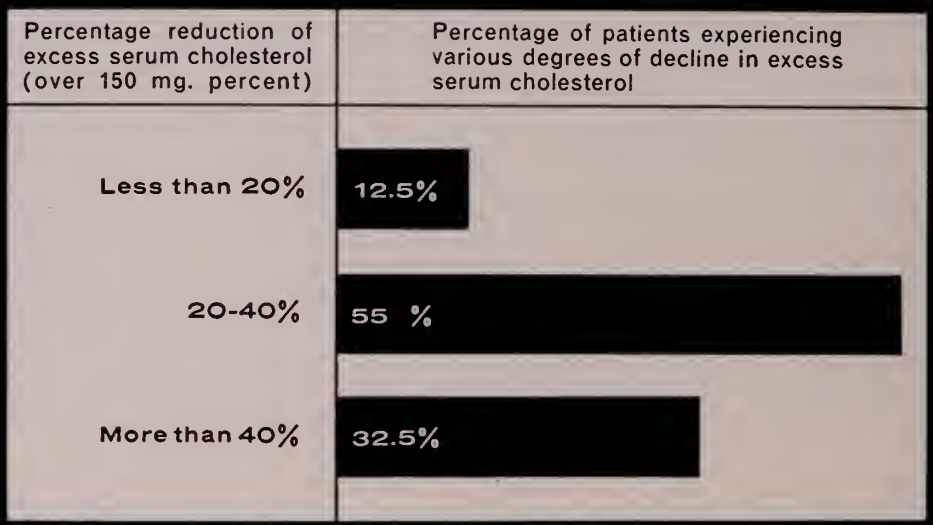
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Hearing Loss in Persons of Advanced Age

Influence of Factors Other Than the Normal Aging Process

ABRAHAM R. HOLLENDER, M.D.
AND
OTTO S. BLUM, M.D.
MIAMI BEACH

Consideration of the subject of hearing loss in persons of advanced age is timely because of the increasing realization that contributions to geriatric problems in general have not been excessive. Moreover, there has been only meager specialistic interest, as far as otolaryngology is concerned.[1] In otology, for example, hearing difficulties in the elderly pose a serious problem because the number of hearing-handicapped persons is on the increase. Bordley[2] correctly stated that such patients actually face more than a hearing loss. "Theirs is a problem of communication. They have already lost the will to overcome the handicap. Many such patients react by going into seclusion. They are much more handicapped than are children with similar degrees of hearing impairment."

Too often, deafness or partial deafness is attributed to aging changes in the body in general and in the auditory mechanism in particular, when, as a matter of fact, the disability can be accounted for merely by conventional causes. In other words, a large percentage of the patients believed to be suffering from so-called senile deafness actually suffers from the types of hearing loss common in younger persons. This fact is significant because typical senile deafness invariably is an irreversible process, while some of the hearing impairments of younger subjects can be influenced favorably by modern therapeutic methods.

Senile Deafness

The term, senile deafness, is in a sense vague, having been applied loosely and often without justification or accuracy, to hearing loss without regard for its cause. The term, presbycusis, is employed by otologists to designate the lessening of the acuteness of hearing that comes with advancing years, but it, too, fails in causative definition.

Typical deafness of senility is of the perceptive type, with an early diminution or loss of high tones. Bone conduction is decreased. There are, as far as is known, alterations in the cochlea and in the cochlear nerve, and these changes are said to account for the reduced hearing. No abnormalities are exhibited by the middle ear. With physiologic aging, the aural process is degenerative and can be considered analogous to degeneration of the retina of the eye.

It is an interesting observation that some persons in the seventh and eight decades of life retain acute hearing function. This can be explained by the fact that in these persons the degenerative process of advancing age has failed to progress and that the hearing function has not been affected adversely by organic disease or other deteriorating causes.

Alexander's studies[3] revealed that the incidence of deafness rose with each successive decade, and between the ages of 65 and 74 years, hearing defects were present in one of every 14 men, and one of every 18 women. A survey of ear, nose and throat problems in older persons, conducted by Hollender and Lytton,[4] disclosed that in hard-of-hearing male adults, almost invariably, the loss was of the nerve or combined type. In hard-of-hearing females, the loss likewise was of the nerve type, with approximately 20 per cent presenting a history of otosclerosis. These observations are not in agreement with those of an earlier investigation, made by Shambaugh,[5] of 165 adults with advanced deafness. This author reported 70 per cent had lost the hearing because of otosclerosis, 12 per cent because of tubotympanic involvement,

From the Division of Otolaryngology, Department of Surgery, University of Miami School of Medicine.
Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

and the remaining 18 per cent because of various other factors. Since Shambaugh's group consisted only of subjects with advanced deafness, this factor could account for the difference in the statistics and observations.

In evaluating the major causes of deafness in elderly persons, the influence of some of the constitutional diseases cannot be disregarded. Included among those of first importance are arteriosclerosis, nephritis, diabetes, syphilis, tuberculosis and the anemias. Other blood disorders, like leukemia, sometimes affect the hearing function.[6] Endocrine imbalances and nutritional deficiencies are known to alter the hearing, though proof of these influences is only partially satisfactory. It can be stated, however, that any organic disease which, directly or indirectly, leads to degeneration of the acoustic nerve may be responsible for hearing loss. With this loss often are associated other annoying symptoms, of which vertigo and tinnitus are the more prominent.[7]

Types of Hearing Loss in Older Persons

Mention already has been made that the types of hearing loss in older persons frequently are no different than those in younger persons. These losses are classified as conductive, receptive and perceptive. As Bordley[2] pointed out, however, the organic lesions responsible for severely impaired hearing in elderly persons result from the accumulations and the degenerations of a lifetime, and seldom is the functional loss owing to a single lesion. This statement is stressed because of the general misunderstanding of the hearing problems in older persons. Although otologists are familiar with the situation, many practitioners are uninformed and regard every hearing impairment which develops in an elderly person as a form of deafness inevitably attributable to aging. As a consequence of this fallacious assumption, patients are incorrectly advised as to the course to pursue.

The fact that hearing defects in a large percentage of older persons are of the classical types is one of the more important developments in geriatric otology. It is important because of the relationship the diagnosis bears to the prognosis.

Present Study

The present investigation was undertaken to determine the nature and cause of hearing loss in a group of 200 persons ranging in ages from 50 to 80 years. The case records were unselected, and therefore, it was believed, represented a cross section of patients who daily consult the otologist because of some hearing problem. In approximately 50 per cent of the subjects, the cause of the deafness could not be attributed to changes incident to the age factor. Actually, the causes responsible for the hearing impairment were similar to those found on the average in persons under 50 years of age. This finding invalidates the thinking of those who without adequate evidence ascribe to physiologic aging all the hearing losses in older persons.

Although improvement in hearing function is not always possible, irrespective of the age factor, if a correct diagnosis is made, patients can, at least, be given the benefit of conventional treatment. In the patients with the classical types of deafness segregated for this study, it was impossible to determine the precise number who improved under treatment. Improvement was the rule and not the exception, however, and in a general way can be said to have been comparable to that usually experienced by younger persons with similar hearing defects.

Diagnostic and Therapeutic Approach for Hard-of-Hearing Older Person

Discussion of the subject thus far has made it clear that diagnosis of the type of deafness suffered by an older person cannot be based merely on conjecture. A comprehensive audiologic and otologic evaluation is imperative for the purpose of accuracy. Before the tests are undertaken, a complete general physical examination of the patient is in order. The results of these tests and examinations should determine the therapeutic course to pursue.

Wilkerson,[8] in a comprehensive review of the subject of presbycusis, emphasized that in examining patients with this disability, the entire science of gerontology must be considered, since normal aging produces a complex psyche and soma. In his opinion, psychiatric and psychologic studies are frequently of value. This aspect has been stressed also by Bordley[2] and others. Failure by the otologist to build up an outlook of optimism in the patient renders psychiatric cooperation an urgent necessity.

General Comment and Conclusions

The problem of aging is one of increasing magnitude. Its multiple aspects require volumes for adequate elucidation. Here we are concerned with one facet of this large problem, that of hearing loss of persons of advanced age. Clinically,

this loss cannot be classed as a single entity unless irreversible changes have developed in the cochlea and the cochlear nerve.

Studies and experience have demonstrated that a large percentage of hearing loss in older persons includes the classical types. With modern therapeutic procedures the prognosis of the classical types of hearing impairment is uninfluenced by the age of the patient. At no time should advanced age be considered as an illness but merely as a regular period of the person's life.[9]

Finally, it should be emphasized that at present the outlook for hard-of-hearing elderly persons is considerably brighter than in the past. Modern developments have spelled a more satisfactory future for most of the hearing-handicapped senior citizens.

Summary

Hearing difficulties in persons of advanced age pose a serious medical and community problem, because the number of hearing-handicapped persons is constantly on the increase.

Too often, deafness or partial deafness is ascribed to irreversible changes in the body and in the auditory organ, when, as a matter of fact, the cause is no different from that responsible for hearing impairment in younger persons.

In elderly subjects with hearing deficiency, the influence of constitutional diseases must be seriously considered.

It has been held that the organic lesions responsible for pronounced hearing impairment in older persons result from the accumulations and degenerations of a lifetime, and seldom is the functional loss owing to a single lesion.[2]

The recognition that hearing defects in a large percentage of older persons are of the classical types is one of the more important developments in geriatric otology.

An analysis of the case records of 200 patients in the older age group, an adequate cross section of those daily consulting the otologist, disclosed that in approximately 50 per cent of the subjects the hearing loss was of the classical types.

Before a conclusive diagnosis is made of the deafness suffered by an older person, a complete physical examination and a comprehensive otologic and audiologic evaluation are imperative.

Unless the hearing loss of an older person can be proved to be due to irreversible organic changes, the prognosis for improving function often is favorable.

The outlook for the hard-of-hearing senior citizens has been brightened considerably through modern developments in diagnosis, therapy and rehabilitation.

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Discussion

Dr. G. Dekle Taylor, Jacksonville: Unfortunately, my experience does not permit me to share the optimism of the essayist regarding the beneficial results of the treatment of deafness in patients in the age group of 50 to 80 years. In reporting an analysis of 200 cases of deafness in this age group, the authors of this paper estimated that approximately half of the patients had so-called classical types of deafness similar to those observed in persons under 50 years of age. They were, however, unable to determine the precise number who improved under treatment. Nevertheless, they were under the impression that improvement was the rule and not the exception. A more critical analysis of the results of therapy in these cases in which conventional types of deafness were diagnosed would be helpful in substantiating or refuting their favorable prognosis.

In contrast to their impression, my experience with patients in this age group leads me to conclude, without statistical analysis, that the large majority of them have irreversible hearing loss. Certainly every effort should be made to establish the correct diagnosis and avoid any tendency to assume that the aging process alone is the etiologic factor. Every patient, regardless of advancing years, should indeed have the benefit of conventional treatment for the classical types of deafness when such treatment is warranted. The patient with otosclerosis, for example, in the 50 to 70 year age group may be benefited by surgical therapy if the secondary nerve involvement is not too extensive. Conductive losses due to serous otitis media or tubotympanitis may be aided by medical treatment. The hearing loss associated with endolymphatic hydrops may be alleviated by medical management, and such management of some constitutional diseases may lessen the local manifestations on the organ of hearing in some instances. It is my opinion, however, that in my practice presbycusis remains the commonest cause of deafness in this specified age group.

I agree with the authors that the outlook of the hard-of-hearing senior citizens has been brightened by rehabilitation. The establishment of excellent hearing centers throughout the nation to assist them in hearing aid evaluation and aural rehabilitation has been a great boon. There is real need in this state for more hearing centers such as are sponsored by the American Hearing Society. We as physicians should alert the public to this need for the establishment of hearing centers throughout the state.

Elderly persons with hearing loss are in dire need of sympathetic understanding and guidance. Reassurance that they will not be totally deaf and encouragement

and guidance offered by the physician will be of great benefit to them. Helping them to adjust to their handicap may be his most effective role.

DR BLUM, closing: The fact that a person wears a hearing aid does not necessarily imply that he came by it through correct channels. It is understandable why some hard-of-hearing persons, especially those in the older age groups, will go directly to a dealer and without knowing the nature of their hearing problem purchase a hearing aid. It is not understandable why some physicians refer hard-of-hearing oldsters to hearing aid dealers when their first move should be to refer these persons to an otologist.

Although the aging process may produce an out-and-out-presbycusis, just as often the cause of the hearing loss is no different than that of younger persons. If this is actually determined, as it should be by modern diagnostic methods, hard-of-hearing persons, irrespective of age, will be given the benefit of recognized treatment procedures, and a fair percentage will respond favorably.

The message we would like to put across is that hearing loss in older persons is not necessarily a deterioration ascribable to the normal aging process. Under no circumstances should these older persons be denied a comprehensive hearing examination, the same as is given younger subjects. Hard-of-hearing older persons should be discouraged from purchasing a hearing aid before consulting an otologist. Cooperation of the medical profession is sought, in this connection, for the benefit of hard-of-hearing oldsters.

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The Prevention and Management Of Football Injuries

Charles R. Burbacher, M.D.
and
David Wike*
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It is the intention of this presentation to discuss in a rather general way the subject of management and prevention of the most common and frequent injuries encountered by a team physician caring for athletes participating in the activity of football. The subject matter is drawn from our experience in dealing with this type of patient at the University of Miami at Coral Gables. As is the case in most branches of medicine and surgery, the prevention of the disease or the injury should be the subject of as much attention as is the therapy of the condition once it has developed.

Preventive Measures

As the sport of football has become more highly organized, various means of prevention of injuries have developed more or less automatically. Following are several factors which have played a great part in comparatively recent times in the prevention of injuries to those participating in this sport.

Equipment.—Through the joint cooperation of sporting goods manufacturers, trainers, coaches and team physicians, the football players' uniforms and protective equipment have undergone such radical change that should a player wearing the equipment of the twenties appear on the gridiron today, he would hardly be recognized as one who intended to participate in the scheduled event.

Rules.—All organized football today is played under rules which pertain to equipment as well as to the technicalities of the game itself. All players must wear a complete set of protective equipment at all times. Any additional protective pads, splints, casts, or similar devices also must conform to rules that are intended to eliminate equipment that could produce additional injury to the athlete who wears it or to his opponent. In most conferences the addition of special equipment must be reported to the officials prior to a game; they in turn inspect it and pass upon such devices or reject them.

Conditioning.—Most coaches and trainers have learned by long and sad experience that a football player cannot be conditioned sufficiently in the first week of practice to allow him to participate efficiently or safely in the first full dress scrimmage. At the University of Miami our players are briefed before they leave school in the spring regarding certain training measures in which they are expected to participate throughout the summer. When they return to school for the opening of fall football practice, the opening event is that of the six minute mile. All candidates for the football squad, upon reporting, must demonstrate their ability to run a mile in six minutes on the running track. Those who fail to do so must continue to run their daily mile until the six minute barrier has been broken. With this event coming up when the potential football player reports for practice, we believe that he learns to make a real attempt to keep himself in condition during the summer months.

Physical Examination.—All athletes participating in an organized sport, regardless of its nature, should have the advantage of a preparticipating physical examination. It is our practice to divide our football squad into two groups for such an examination. One group is made up of those with whom we are acquainted through their previous participation, upon whom we have certain medical records and a history of previous injuries. The other consists of those with whom we are dealing for the first time. It is obvious that this group should undergo a more thorough, complete general physical examination, in order that a base line may be determined. It is especially important in the instance of football players to make specific inquiry as to past injuries. We believe that rather complete records should be maintained on all athletes, beginning with the initial examination, with additional entries pertaining to all future illnesses and injuries.

*Trainer, Athletic Department, University of Miami.

Head Injuries

The improved type of football headgear has reduced intracranial injuries to a minimum. We continue, however, to encounter a mild concussion type of injury each season. If a player who is down on the field is observed to be definitely unconscious, he should be removed from the playing field on a stretcher and observed for a brief period of time on the side line and in the dressing room. If the coma persists, it is obvious that he should be immediately removed to a hospital for neurosurgical evaluation and care. The usual mild concussion produces a dazed player who is temporarily mentally confused. If examination and interrogation on the field reveal that he lacks orientation as to his whereabouts, the score, or his blocking assignment on a stated play, he should be removed to the side line and observed closely until it is determined that his cerebration is intact. We believe that he may then safely resume playing, but the trainer or team physician will watch his reactions closely through the remainder of the game. Occasionally a player will become somewhat prone to show repeated episodes of this mild type of concussion. In such a case, we think that neurologic or neurosurgical evaluation is indicated before he is permitted to experience these temporary blackouts or dazed periods game after game.

Spinal Injuries

Although each season we read of a few instances of fracture of the cervical spine with paralysis or death, the frequency of this type of injury has been reduced materially in recent years in organized football. In our opinion this gratifying development has come about largely through conditioning of the athlete and through closer supervision and organization of the sport. Anyone who has complaints of pain and limitation of motion, especially with radiation of discomfort to either or both upper extremities following a neck injury, should have adequate roentgen examination before being permitted to resume playing. The occasional stiff neck can usually be promptly relieved by adequate physical therapeutic measures, but we do not think that a player should be permitted to resume the contact activities of the sport so long as any true limitation of motion exists. The occasional low back strain or sprain likewise is alleviated in the course of a few days by physical therapy and rest. If the symptoms and disability persist, roentgen examination is indicated. It is our experience that, again because of conditioning, low back complaints are surprisingly infrequent and, if they develop, are usually superimposed upon some congenital anomalous development in the lower lumbar spine. At the University of Miami we have not encountered a disk lesion developing during a player's active football career.

Shoulder Injuries

Despite the advances and development of protective shoulder equipment, injuries in the region of the shoulder girdle continue to be, along with knee injuries, the proverbial headache for football trainers and team physicians. The most common shoulder injury is that of injury at the acromioclavicular articulation (shoulder separation). Dislocation at the acromioclavicular articulation lends itself to a rather obvious immediate diagnosis, but specific measures should be carried out to determine the extent of the injury. Fortunately, most of the injuries of this type are of an incomplete nature in that there has been tearing of the ligaments at the joint itself, but the infraclavicular ligaments (conoid and trapezoid) remain intact or are only partially ruptured.

In the complete dislocation all supporting ligaments of the articulation have been completely ruptured, allowing the joint to become completely dislocated. Differential diagnosis must be made by roentgen examination. The technic consists of making an anteroposterior examination of the area with the patient erect and holding approximately 10 pounds of weight in the hand of the affected side. We have had the unfortunate experience on a few occasions of having had roentgen examination made with the patient in a supine position in which a normal relationship between the distal clavicle and acromion process was demonstrated only to observe a complete dislocation to be present the following day when the patient was examined in an erect position. The incomplete separation is treated by a period of rest until the acute symptoms subside, and the player with this type of injury may usually return to full duty in a period of one to three weeks. With a complete dislocation the athlete is retired for the remainder of the season, and the condition in our experience is best treated by surgical repair.

Dislocations at the Shoulder Joint

Here again the shoulder pad has not been designed that can satisfactorily protect the athlete against this type of injury. In our experience

shoulder dislocations in athletes are rarely accompanied by fracture, as is frequently seen in older persons. It is our practice, after making a diagnosis which is fairly obvious, to make an immediate attempt at reduction in the dressing room without anesthesia or with the analgesia of intravenous morphine. It follows that if this attempt is unsuccessful after a reasonable amount of manipulation, an immediate reduction under general anesthesia should be done at a hospital. Postreduction care should be in the nature of at least four weeks' immoblization with the arm restricted in a position of adduction. The usual investigation as to the possibility of nervous or vascular damage should be made in each case of shoulder dislocation.

Elbow Dislocation

Fortunately, this injury is comparatively rare in football. In our experience it retires the player for the remainder of the current season because of the prolonged period of limited motion that follows this injury.

Injuries in the Region of the Hip

In our experience the most frequent injury encountered in this region is that of repeated contusion in the area of the iliac crest. Fortunately, this is not a serious injury in that it does not impair the player's efficiency or ability to protect himself, but because of the fact that the pain on contact is severe, a player suffering from this type of injury loses some of his desire and incentive to block in his usual manner. This is one condition in which we believe that the use of local anesthesia for temporary relief of discomfort is safe and ethical.

Injuries at the Knee Joint

Injuries at the knee joint continue to be the bugaboo of football players, trainers, coaches and team physicians. This situation is due primarily to the fact that anatomically the knee is the most unstable major joint of the body. The osseous architecture is such that no structural bony stability exists. All of the stability of the joint depends upon the supporting ligaments and the activating musculature of the articulation. Protective equipment to add stability to the knee has not been designed (and in our opinion never will be) that would lend support to this joint and still permit an athlete to run in an efficient manner. In the present football uniform there is an anterior pad which prevents severe contusions and abrasions of the knee; otherwise, this joint is on its own. Conditioning of the leg musculature and the ability of the player to avoid blockers and tacklers successfully are the only equipment the player possesses in protecting the knee, which is the target for most of his opponents' physical efforts.

When a knee injury is incurred, an immediate examination by competent hands is indeed indicated. In the course of a few minutes hemorrhage into the joint may mask many of the cardinal signs necessary for a differential diagnosis of the various knee injuries encountered in this sport. Routinely we first examine for gross evidence of fracture of the lower portion of the femur or upper portion of the tibia. If these signs are absent, the knee is tested for the ability of complete active and passive extension, which is almost always limited in a severe meniscus injury. The drawer sign test for possible cruciate ligament injury and abduction and adduction of the tibia on the femur to test collateral ligament stability should all be carried out before the general reaction of hemorrhage, edema and effusion develops. Definitive treatment of one or more of these injuries will depend upon the diagnosis and does not come within the scope of this paper. General measures include the immediate application of ice, pressure, and semirigid or rigid splinting if pain and disability are pronounced. If distention of the knee is excessive, repeated aspirations may be necessary. We believe that all knee injuries except the obviously minor sprains should be studied roentgenographically to rule out incomplete fractures, avulsion of the tibial spines or osseous pathology such as osteochondritis dissecans.

Foot and Ankle Injuries

One of the most frequent injuries to athletes is the sprained ankle. The various methods of taping of the ankle in the sports in which it is indicated will usually serve to minimize the injury and prevent complete rupture of the ligament. Despite the most efficient "tape job," however, the foot and ankle are prone to the inversion type of trauma resulting in some degree of damage to the lateral ligaments. At the time of injury the athlete remains on the ground and complains of his leg and foot; an immediate diagnosis is desirable. He will be seen at once by the trainer, who will determine whether or not he is to continue or be replaced. If the injury occurs in practice, it is usually the responsibility

of the trainer to make this diagnosis and institute treatment. If it occurs during a scheduled event, the trainer may or may not have the assistance of an attending physician to aid him in the diagnosis and make recommendations as to whether or not the player should continue and what treatment should be instituted.

In order to have a common ground for discussion as well as treatment of ankle sprains, Dr. Don H. O'Donoghue of the University of Oklahoma has classified this injury in three categories: (1) mild, (2) moderate and (3) severe.

MILD ANKLE SPRAIN.—The mild ankle sprain is one in which there has been a partial tear of some portion of the ligament or its attachment which is not sufficiently extensive to produce actual functional weakness of the involved structure. In this type of sprain we find rather minimal complaints; the swelling will be slight, tenderness will be localized, and there will be only mild disability. The player will usually have gotten to his feet unassisted and will be trying to "work it out." Examination will reveal no abnormal motion at the joint, but there will be some pain upon forced active or passive motion of inversion.

A roentgenogram of this type of injury will show no abnormalities. With the mild ankle sprain no specific or extensive treatment is necessary. Application of cold packs for a short period of time and restrapping are usually effective in relieving the discomfort and disability, and the player may safely be allowed to resume playing. If the pain and disability are excessive or sufficient to render the player ineffective, treatment by strapping and by limitation of activity for a period of a few days usually effects an entirely satisfactory recovery. The strapping should be continued until the discomfort has completely disappeared. It is obvious that the criteria for this type of management depend upon an accurate diagnosis to be sure that the injury is only a mild type of sprain.

MODERATE ANKLE SPRAIN.—This second classification is applied to the group of injuries in which there has been more extensive damage to the ligaments but in which there is not as yet actual complete interruption of the continuity. Injury will have been incurred from a sharp acute inversion of the ankle. The patient will usually be on the ground and exhibit evidence or rather severe, immediate pain. He may be able to stand, but will not have put forth much effort to work out his injury. There will be immediate swelling and evidence of a local hematoma which will first be sharply localized, but will rapidly spread out through the area.

Upon immediate examination, local tenderness will give a clue as to what ligament is injured, but in the course of a few minutes to a few hours the discomfort and tenderness will be so diffuse as to prevent sharp localization of the injury. Roentgen examination usually gives negative results unless the injury has occurred at the point of ligamentous insertion in the bone where a few bone chips may be noted to have been pulled free. The roentgenograms and clinical examination in this type of injury will not reveal evidence of abnormal mobility at the ankle joint. Treatment of such a condition must be more extensive and specific than that of a mild sprain where the aim of the treatment is largely to relieve the discomfort. In this type of injury there are two aims in the treatment; the first one is to relieve the present injury, and the second is to prevent further injury. The ligament may have lost most of its structural strength, and slight further injury could probably result in a complete laceration of the structure.

It is well known that in many localities local injection treatment, employing novocain and hyaluronidase, varidase, or some similar preparation, is employed. If such treatment is to be used, there is an indication for it in this type of injury. At the University of Miami we have continued to employ the modalities of physical medicine in the treatment of sprains with satisfactory results. It does not follow that we condemn injection treatment. It is our practice immediately to apply pressure and ice; usually we continue this treatment for a period of 12 to 24 hours. The use of pressure and cold has a threefold purpose: (1) It affords relief of the pain of the injury, (2) it helps to reduce excessive swelling, and (3) it prevents excessive bleeding at the site of injury.

One of us (D. W.) has been using a sponge-like plastic preparation which facilitates the application of cold and pressure in that the material can be repeatedly immersed in ice water, applied to the part and wrapped in an elastic bandage. This material serves as a source of cold and pressure at the same time. As soon as the swelling is controlled, the ankle should be protected by splinting in a semirigid dressing consisting of sheet wadding and elastic bandages until the swelling further subsides. At this time, if further

examination indicates that a considerable degree of ligamentous damage is present, a cast should be applied. The point may be raised that this measure is unnecessarily prolonging the period of disability, but it follows that if actual ligamentous damage is present, the period of disability will extend for several weeks. It is our belief that a complete rest in a cast will actually, in the end, shorten the period of disability and afford opportunity for more complete healing, thereby reducing the incidence of future injury or possible permanent disability. Following removal of the cast, which is worn from one to two weeks, there probably will be some local tenderness, and at this time an adequate strapping should be employed. Strapping should be continued until all symptoms have completely subsided. Such an injury usually produces disability for athletic service for a period of three to four weeks.

Severe Ankle Sprain.—The third classification of ankle injuries is the severe sprain. In this type there is complete tearing of the ligamentous structure. The findings here will be essentially the same as those seen in a moderate sprain, namely, tenderness, swelling, and pain on reproduction of the force of injury, but all symptoms will be more severe. There will be immediate disability. Immediate examination may reveal abnormal rocking motion at the ankle, and this finding may also be demonstrated on roentgen examination. Treatment of this injury is essentially the same as that described and employed for the moderate sprain. If those responsible for handling the injury are of the group that employs injection methods, there is definitely an indication in this severe injury. As previously stated, at the University of Miami we still stay with the modalities of physical medicine. With a severe ankle sprain, that is, where there is complete rupture of one or more of the supporting ligaments of the joint, cast treatment is definitely indicated. It has been our thought that with adequate immobilization over a period of three to four weeks followed by protective strapping and gradual return to activity, our results have been entirely satisfactory.

In some circles surgical repair of the ligament has been advised and is carried out almost routinely. We do not condemn this method of treatment inasmuch as the results have been satisfactory. We have not found it necessary to repair surgically ligamentous injuries of the ankle which are not complicated by fracture. Fortunately, the complete ligamentous rupture is comparatively infrequent, because with modern training methods the various ankle strappings employed usually prevent the foot from being everted or inverted through a range sufficient to rupture the ligament completely.

Fractures.—Fractures about the foot and ankle in supervised athletic activities at the University of Miami, fortunately, have been relatively infrequent. We believe that this circumstance among our football players is the result of two factors: (1) conditioning of the supporting musculature of the foot and ankle and (2) adequate and effective strapping. This fact is well borne out in press notices regarding fractures of the ankle and foot among athletes in the nation. There are no available statistics to bear this out, but it is our opinion that we hear of many more ankle and foot fractures among baseball players than we do among the football players. It is not common practice routinely to strap ankles in organized baseball.

It is our opinion that the subject of traumatic myositis (charleyhorse) could best be presented by one who encounters the condition more frequently and who in the opinion of C.R.B. has been more successful in reducing the period of disability from such an injury in a more successful manner than most medical practitioners. Accordingly, one of us (D.W.) has prepared the following opinion regarding the management of the so-called "American charleyhorse:"

Routine Management of Soft Tissue Contusions Incurred in Contact Sports

Soft tissue contusions and the American charleyhorse are synonymous; but to the coach and player these injuries also include muscular conditions that are caused by a violent straining or pulling of a muscle. Regardless of the cause, the primary physiologic pathology in most cases is about the same. Thus, the management of either case will be followed in much the same manner.

Contusions in sports present themselves frequently in the following order: the quadriceps group, the forearm, the anterior iliac crest, the brachial muscles, and the lower leg group, particularly the calf of the leg.

For reasons of prognosis and as an aid in wise management of such contusions, I find it possible to divide these injuries into two categories. First, there are those of moderate severity which cause the athlete to complain during the course of the game, but which do not affect his play to any noticeable degree. This type of in-

jury appears to be most acute after the "cooling off" period—usually the following morning. With proper care, as will be described later in this article, the largest percentage in this category will be ready for active participation within two to four days. Those of a very mild nature usually leave the athlete free of any discomfort after he warms up for his next practice session.

Contusions in the second category are obviously those of a more severe nature. From my experience I have learned that when an athlete has received a violent blow to one of the aforementioned anatomic parts and shows emotional stress of pain and in addition lacks normal function, one may be certain that he will be unable to participate actively for a period ranging from two to six weeks. Regardless of his constitution and willingness to carry on, he is just not able to perform satisfactorily immediately or shortly following the injury. In an average group of 75 football players here at the University of Miami, I have found that approximately three of this group will not be able to participate actively from five to 65 days because of a severe contusion to some one of the previously mentioned parts. One of these three players will still be inactive after 16 days from the time of occurrence of the injury. In my observation of all types of sports injuries, I have noticed that players receiving a violent blow in the area of the brachial muscles seem to suffer the most pain.

Success in dealing with these injuries lies with the immediate application of pressure bandaging and ice packs. With the moderate contusions I apply a counterirritant and a pressure bandage at the first opportunity. The object of the pressure bandage is twofold; it provides moderate pressure to control hemorrhage and also a mild massaging effect upon movement of the part. I recommend extending the pressure bandage at least six inches above and below the focal point of the injury. "Bunching" of a pressure bandage by the inexperienced has caused some unnecessary conditions to exist.

The following day I begin the application of either infra-red or moist heat packs. This will depend upon the degree of hemorrhage; if there are signs of massive hemorrhage, the boy is instructed to continue with the pressure bandage and ice packs. With the contusion of moderate severity, 20 minutes of heat is followed by eight to 10 minutes of Ultra Sonic at 1.5 to 2 watts per square centimeter, depending upon the size of the area to be treated. After the Ultra Sonic treatment, light stroking and kneading massage is applied for about five minutes. The treatment is concluded with the application of a mild counterirritant and a pressure bandage. One now arrives at the critical point of management. Psychology, experience, and mostly good sense must be used. What shall this athlete's activities entail? If he has at least 95 per cent functional efficiency, he will be ready for full duty. Ninety to 94 per cent efficiency usually will afford participation in all team drills, but NO CONTACT. Anything less than 90 per cent must be considered low efficiency and must be directly supervised by the trainer. This includes activities such as walking, jogging, running, and specific exercises for the given condition. One can "run out" a charleyhorse but, in my opinion, not under the stress and strain of full scale activity.

To express this rating scale is somewhat difficult. It is based, however, on manual muscle testing and the range of motion in which the muscle or muscles normally move their respective anatomic parts. The object, of course, is to test for muscle power and/or any shortening of muscles because of spasm. A weakness will result in loss of movement in the respect that the muscle cannot move the part through its normal range of motion, decreasing the distance between the origin and the insertion. A shortening will result in loss of motion in the respect that the muscle cannot be elongated through its full range of motion, either passively or by its opposing muscle. In a sense my grading scale is very simple; 95 per cent plus he can, 90 per cent plus he almost can, and 89 per cent minus he cannot.

The procedures mentioned are followed in all contusions except those contracted around the brachial muscles. This injury has been on the increase in recent years because of new technics in offensive and defensive football play. A pressure bandage is applied along with a mild counterirritant, and the elbow is then put in a sling for at least 48 hours. Keeping the elbow in a flexed position along with the application of ice packs during the acute stage of this injury has proved invaluable. Heat and massage are contraindicated during this stage as they tend to aggravate the condition. The primary effect in this type of contusion is painful as well as distressing to the athlete. It is, however, the possible secondary effect that frequently develops which causes concern. The formation of an exostosis somewhere

along the origin of the brachioradialis is not too uncommon. Repeated trauma, in my opinion, will always result in surgical repair. Special padding while in the acute stage is seldom—if ever—of much value.

Contusions of a more severe nature are no more difficult to manage than moderate ones except for the difficulty of convincing the athlete and, more often, the coach, of the seriousness of the injury. Physical therapy is given daily which consists of heat applications, Ultra Sonic, massage, and therapeutic exercises. Systemic chemotherapy has been tried in adjunct therapy but with no particular dramatic results. Our medical staff and I—from my own experiences—find no substitute for sound, scientific, physical therapy.

The whirlpool bath is probably the most popular modality in the high schools today. I, however, think it the most misused modality. There seems to be only one operating temperature, 110 degrees. I frequently see high school athletes suffering with severe contusions in one of the quadriceps muscles. The typical history is: whirlpool bath two to three times a day at 110 degrees plus plenty of overuse. The more acute the injury, the lower the intensity of heat should be, the minimum being 102 degrees and the maximum, 110. What ever the method of heat application may be, the intensity of heat and the acuteness of the injury must be kept in mind.

Massage and therapeutic exercises in addition to heat bring most satisfying results. Heat alone is not the answer to some of the so-called dramatic recoveries read about. Contusions of average severity remain acute from three to five days. Definite progress should be noted thereafter; if not, I consider the injury chronic as a result of poor management.

Summary

It is obvious that many of the possible injuries encountered in the sport of football have not been mentioned in this article. It was not our intention to cover completely the field of treatment of football injuries.

The necessity of adequate supervision of the sport, insofar as prevention, treatment and prognosis are concerned, is emphasized.

Preventive measures are reviewed, and injuries of the head, spine, shoulder, elbow, hip, knee, foot and ankle are discussed. In addition, the subject of traumatic myositis is presented from the viewpoint of the athletic trainer.

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The Pediatrician and Behavior Problems Of Children

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In talking to you about behavior problems, and recognizing the fact that I certainly cannot be expected to give a recipe for the diagnosis and treatment of all of the behavior problems that plague a pediatrician, I shall attempt to work out with you some points of reference by which we might approach any behavior problem. I hope thereby to help us see where, as pediatricians, we can function, and where, as pediatricians, we need to refer parents to someone else, perhaps a psychiatrist, who can help them.

YESTERDAY TODAY TOMORROW

I think as I talk you will see why I have put these three words on the blackboard. If we consider that behavior has meaning, then we see that there is some reason for anyone's behavior at any given instant and that the behavior of any instant is the product of past experiences of the individual, what he has learned through his experiences in the past, plus the present situation in which he finds himself and some consideration of the future, in terms of fear or hopes. These three ingredients account for behavior at any instant. So it boils down to yesterday, today and tomorrow, to produce the behavior of any instant of today. We can approach behavior that a parent tells us about, or behavior we see in the office or in the hospital by asking ourselves the question, "What is this behavior telling me? What is it saying? What does it mean?" Then we can question ourselves, according to the pattern that I tried to sketch for you yesterday: "What is this like in terms of normal growth pattern? What does this remind me of, this behavior that I see? What did it mean in that normal period of growth? Why would this behavior be necessary today? Why does the child need to have this behavior that we see now?"

We ask ourselves: "What is today for this child; how does it look through his eyes? What strain is he under; what changes might there be? Who are the persons in the picture?" Then, "What does this lead to in the consideration of his future? What is he hoping for? What is he afraid of?" Take an illustration, not afield from pediatrics, and one illustrated by the adult male in whom, in the service, enuresis developed. (There was quite an incidence of enuresis among naval personnel.) What did this mean in terms of normal growth? What was the whole business of bladder control in terms of the normal growth and development in the child? As we said yesterday, this had much to do with the period of normal growth and development when the youngster, having developed neurologically to the point where he could have conscious voluntary control of sphincters, learned that this behavior was prized, or valued, by society, by his parents particularly, and that this was one of the ways that he could show that he was no longer a baby unable to care for himself. This was a way for him to show that he was now more mature and could take care of himself, taking responsibility in this area. We also said that around the development of toilet behavior, the whole business of who is boss revolves, because this is something in which two people, child and parent, have concern, though the actual control belongs to the child. What does this have to do with a man in the Navy who is now wetting his bed? Maybe we can see if we look at the behavior from the standpoint of emotional growth and development.

What did this mean in normal childhood when a child gives up the childishness of wetting himself and, becoming more grown-up, goes to the toilet when he has to? It meant that he valued this independent activity, that it was not too threatening to him to give up his mother's activity in this area, but it was something he could give up, not only because his mother liked him when he was more civilized and trained in this fashion, but also because, retaining her love, and having an impulse to grow toward independence, he was able to make this step.

Thinking in this way, about our Navy man with enuresis, in terms of normal growth, this

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man may be uneasy in the situation in which he finds himself and perhaps he does not want to be so grown-up. Maybe by wetting the bed he is saying, "Who wants to take responsibility for himself in this situation?" He is not fully responsible for himself, for there are many other people planning for him and he is really being maneuvered by other forces. This threat to his life is present, and maybe this behavior is saying, "Look, I still want to be a baby, I want out of this," and, consciously, of course, he knows there is no place for a man with enuresis in the Navy. If he had said he had enuresis, he would not have been accepted in the Navy, but this man did not have the problem of enuresis when he entered the service. Unconsciously, however, through this symptom, he is expressing his anxiety about the situation he is in, the desire to be out of it, and there develops a meaningful bit of behavior that might bring about the results that he wants. So the "Why would it be necessary?" today, for this man, becomes obvious. He wants to be taken care of, he wants to be protected, he wants to be out of the situation that is life-threatening to him. In other words, independent, mature behavior is perhaps more dangerous than dependent, immature behavior when one is involved in war. In terms of "What does this lead to for the future?" it would get him out of this situation that mobilizes more anxiety than he is able to handle at the present time. This sort of approach to the behavior problems of children can be a great help to us in pediatrics.

There are three major groups of the commoner behavior problems that we meet in practice:

Problems Closely Related to Aspects of Physical Care that Closely Involve the Mother

The behavior problems that are associated with the most intimate aspects of child rearing and the most intimate aspects of the mother-child relationship are concerned with physical care.

Going back to what we said yesterday, when the child's physical and psychologic needs were being met by his mother, his psychologic relationship (emotional relationship) with her was developing. Thus, if faced with a feeding problem, whether vomiting, excessive crying, colic, or whatever, look at it in terms of, "What else is in this feeding besides the formula or the food? What is this behavior of the child to this feeding? What is this telling about him? What is this telling me about the mother-child relationship? What is it telling me about this baby neurologically? What is it telling me about his physical equipment, his physical adequacy, his neurologic integration?" Babies are not all the same, and there seem to be some that demand more physical attention to begin with than others. You see babies in newborn nurseries, and they are not all alike. There are some that look as if they are born ready to strike out and lick the world, and there are others that look like limp washrags. Yet, they all fall within the broad span of normal. (I am not talking about children who have brain injury.) Nevertheless, there is a difference in their vitality, and they cannot help but be different in the way in which they are going to meet situations, and the way in which the mother-child relationship is going to get started.

Mothers differ, too. Perhaps psychiatrists have overemphasized the mother-child relationship in terms of what mothers do to babies or fail to do to babies. Maybe we have not paid nearly enough attention to the difference in babies. This might lead us closer to the answer to some of the questions that parents ask us, such as "I cannot understand why this child is like he is and why my other children are all right." Here is the question that stumps us in medicine, but maybe the difference in the individual infant and in the way he grows through childhood is something that deserves much more thought than just assuming that any individual will react in the same way depending on how he is treated—not only according to how he is treated, but also according to his reacting mechanism. Mothers being different, we might approach an understanding of the feeding problem by "What are the mother's needs in this situation? Is her need to take care of this baby or to be concerned with him? Is he accepted in the first place? Is he only accepted for a reason within her psychology? Is something going on within this mother now, or has something been going on, that has made it more important for her to show this concern, or this tension, around the life-saving aspects of getting food into the baby, or that has impressed the overconcern of the mother's attempts at getting food into the baby? Why should this be such a pressing problem to her?" Maybe we can find why this might be.

We can expect people to have a good deal of predictability about them. If a mother had a hard time retaining a pregnancy, we can expect

her to have more anxiety in the life-saving aspects of early child rearing and feeding. We can expect her to have more anxiety about whether or not the baby is breathing properly or is covered. If she has lost a child before this baby, we can expect her to have more anxiety. Why would this not be natural? If there are any reservoirs of anxiety in such a parent, this problem would mobilize more. A mother who has had a severe health problem herself could be expected to be health-conscious or body-oriented towards her baby. The number of mothers, for instance, who either have tuberculosis themselves, or in whose family there has been tuberculosis, often have fat children. Get them to talking about gain in weight and you will see they are not upset by the beginning of obesity in the child; in fact, they really like it. This makes them feel good. It is not long before such a mother is able to verbalize it and tell you why; gain in weight is related, in her mind, to health, and loss in weight to illness. There was emphasis on the patient's weight while she had tuberculosis and during her recovery period. To be heavier was to be healthier, in the psychology of those parents who have had tuberculosis, or had it in the family. I have seen women in whose families the actual tuberculosis did not amount to much, but the household revolved about the cured father and the feeding of the father, so that food was emphasized in terms of health building. When this "little girl" grows up and has her first baby, without realizing it, she pushes food and has to have a heavy, rapidly gaining baby.

An older mother, who had her first baby toward the end of the child-rearing period, can be expected to have more concern about her baby than younger mothers. The woman who was sickly herself in childhood (though the indisposition may not have amounted to anything medically) grows up, dates late, marries later and thinks of herself as an inadequate physical specimen. She cannot help but feel some inadequacy, psychologically, as a feminine person. Although she marries, becomes pregnant and has a baby, she is likely to find fault in him because she is looking for the same kind of inadequacy in her offspring. It may, or may not, be present, but the woman who approaches maternity with feelings of physical inadequacy herself can be expected to have excessive concern about the physical endowment and physical adequacy of her baby.

Another problem that is closely related to the earliest activity of mothers with their babies is, of course, the bowel problem. Constipation, or concern about stools being loose, may be thought of by associating to, "What else does this mean to this mother? What are her concerns about elimination?" Often women who have constipation problems themselves are looking for them in their young. This situation we see over and over again. What does all of this mean to the mother? What is the production of the stool by a toddler besides elimination? What about the discipline involved? "Do what I want you to do; be a good boy." How we associate cleanliness with godliness! "If you're a clean boy, you're good; if you're dirty, you're bad." What about this aspect of it? For whom is he doing this then? Is this behavior that he is supposed to be giving to his mother and is this more than he wants to do? Is he withholding his stool to show his resistance to excessive demands?

Soiling can be looked at similarly. It can be an indication of being a baby. "Look, Mom, I can't take care of myself; take care of me." This might mean there is too much pressure to grow up, to be independent and conform to adult standards before the child is ready. Soiling may have an infantile component, but it also has a hostile component. When we mess something up, we are showing hostility, and when children soil, they are not just being babies, but they are being angry, resentful children. Soiling or withholding can be just as hostile. Perhaps the child has even more anxiety when he dare not use his stool to express hostility; so he shows his resentment and angry feelings by holding onto it. He may be thinking this will not bring him punishment as would being messy, or soiling.

Similarly, with bedwetting: There can be a dependent baby component to it, and it can also have a hostile component to it. When you wet somebody else's sheets, certainly you are not feeling a great deal of love for that person. It always interests me when I find a mother who is sleeping in bed with an older child who is wetting the bed. When you ask such a mother why she does so, you get a variety of answers. It is not always that she is looking for the companionship of this child and wants the child to stick close to her. A woman living alone, a widow perhaps, has a daughter sleep in bed with her, nine or 10 years old. This girl wets her bed, and you wonder why in the world anyone would live in this

way. We wonder why she does not let the child have her own bed to wet. Often, this is a wonderful way for a mother to cover up her really basic resentment of the demands of the child on her, and, in allowing herself to be wet upon by the child, she covers up some of the uncomfortable feelings she has of wanting to be rid of the youngster anyhow. Whenever you have behavior that seems to be irrational, this is a good key and may unlock the situation for you. Asking, you may find that the child is being exploited as a companion for a lonely woman, or that she is really being sucked dry by a woman whose life is empty. In this way, growth is interfered with, and this youngster's behavior is telling us how she feels about the situation in which she finds herself. Her mother is perfectly willing to perpetuate it because she needs to camouflage the rejecting feelings which would make her uncomfortable.

Some sleep problems can be similarly understood. Certainly mothering activities will revolve around feeding, elimination and sleeping. In the sleeping problem, too, we ask ourselves: "Who is anxious about going to bed, the separation, the dark? Is it the child, or is it, perhaps, the mother? Again, what is likely to make a mother uneasy or anxious about separating from her child?" She may have some fears left over from her own childhood, of what could happen when you were away from mamma in the dark. She may have some fears about her child, just as might have been shown in her concern about his feeding in terms of his life; he might smother if she is not real close to see that he is breathing properly. This may again be a way in which she covers up, by what looks like overconcern, the anxiety stirred by some negative feelings that she has for her baby. The most accepting and comfortable parents are not the ones who have to be looking in on their children all the time, and who ask the pediatrician, "Is this child doing all right, is he gaining enough, is he really a satisfactory child?" The parents who are overdoing the care and concern are less likely to be the more fully accepting parents.

This is a lead the mother gives the pediatrician frequently. It is an annoying lead, this overconcern and worry about something. You may not be worried about this, as a pediatrician, because there is not anything to worry about, but her worry about it is the tip-off. Pointing this out to the mother by saying, "Why in the world are you so worried, what do you think is going to happen to that child?" helps the anxiety break through, and often there follows a statement of what you really want to know. Now you have something you can work with and you can do some debunking about the irrational concerns she may have.

With sleep problems and other behavior that concerns them, mothers will ask for help and yet be doing everything possible to perpetuate the disturbances. All children show some concern about going to bed, some little concern about the dark. This is more than just not wanting to miss out on what is going on in the family, not wanting to be sent off to bed. Any child may be expected to ask mother to remain with him or to lie down with him. Some requests are met by an overready acceptance. Parents need to be told that if the mother is really not afraid of the dark herself and she knows nothing is going to happen to her child, that when he shows her he is afraid, her ability to reassure him, her own security, would nip any problem like this before it got started. If, on the other hand, the parent has some insecurity herself about this problem, whether it has to do with ancient fears of the dark or whether it has to do with specific concern about this youngster, and she responds to this initial request by lying down with the child, she is reinforcing this anxiety. By doing so she is saying, "Yes, there's something to be afraid of, and mamma will lie down with you to see that nothing happens."

Many parents today are confused as to what they should do, and otherwise secure parents might think that this is the modern, considerate thing to do, to lie down with the child who might ask for this initially. The pediatrician can be most helpful in pointing out to the mother that this is not necessarily the best thing to do, that this may reinforce the anxiety which the child already has. We can be reassuring to the parent if we see her job as parent, and ours as pediatrician, is not to insulate the child from all anxiety, but to help him to live with what anxiety he has to live with; none of us are free of anxiety and this is only a wish on the part of the parent that she could prevent her child from having any anxiety. The better parent, and the more realistic parent, helps the youngster live with the anxiety that he has. You do not learn to tolerate anxiety by never having it. Some parents seem to

think that their job is to prevent any anxiety (maybe called "frustration") in their child.

Behavior Problems Closely Related to Some Aspect of Discipline-Learning

By discipline-learning, we mean discipline in its broadest sense. Again, I should like to mention feeding problems because there are feeding problems that are more related to the discipline of feeding than the younger version of feeding problems mentioned previously.

Some children have parents who cannot say no and mean it. Any discipline-learning has to do with how you say no, mean no, and say it every time in a particular situation, so that the child learns to say no to himself and to develop internal controls of his own, a conscience. There are some feeding problems that are related closely to this. Certainly the obese person is undisciplined where eating is concerned. Whatever the reason, he is unable to discipline himself against overeating. Some children do not have the opportunity to develop discipline in eating because somebody, mother, father or someone in the household, needs to have him overeat, is unable to say no to him when he wants food, or says he wants food when he really wants something else. The food that the parent gives him thus becomes a symbol for something else with consequent overfeeding. Having had this experience, a child seeks food in certain situations when he may be unhappy, feeling lonely or hungry for something other than actual food. Should the parent respond by feeding, he contributes to the obesity.

Certainly stealing, the misuse of property, or the appropriation of someone else's property, has to do with the learning of another kind of discipline—the respect for private property. How has this been learned in this particular family? When faced with a problem having to do with delinquent behavior, always look for the inconsistency and/or the delinquency in the parent. Many parents are delinquent. To be sure, they do not rob banks, or shoot people, and they do not tangle with the law, but they may be most delinquent in dealing with children. The parent who permits his child to drive before he has a learner's permit is being delinquent. There is no excuse, no rationalization for this kind of behavior.

The child who is interested in matches lights a match, and his parent says, "Come now, if you want to light a match, we'll light matches together." This is not making control easy for him. There is no reason to light a match unless there is a very good reason to light a match. Fire is something to be respected and to be used in a careful way. There is no such thing as a "normal need" to strike matches. Parents need to hear this and that it is most confusing to a child when the parent permits the striking of matches when he is with him, but does not permit it at another time.

This same attitude holds for stealing. Stealing is stealing. Whether you land in jail for it or not, it is still stealing. Although the petty thievery of childhood can be understood (to be sure it is not rare), it is not normal. The parent who comes to you because someone else is now concerned about his child's stealing, or because he cannot take the child in the store because he swipes things, will finally admit to you, when you question him, that the child has been stealing things before. "Oh, we've always had a little bit of that, but only at home." As if this was not stealing! If you take something that belongs to a brother, this is not stealing, but if you take something from another boy's locker at school, this is stealing. The delinquent attitude on the part of the parent is what gets in the way of learning the discipline of respect for private property.

Lying can be discussed here. Why is the child lying? A child may lie because the punishment for what he has done is so severe that he feels he must lie. On the other hand, let us look at the discipline and let us look at the punishment. Punishment becomes necessary only when discipline fails. If we could breed a race of perfectly disciplined people, we would need no punishment. We have not been able to do that yet. Punishment and discipline are not synonymous. Discipline may not have had adequate time to be learned by the youngster, and the punishment for barely learned discipline, or for a break in discipline, is so severe that the child is actually pushed into lying.

Problems Closely Related to Triangle or Social Situations

Three people constitute a group, that is, a triangle situation. The roots of social problems, triangle problems, are in the family domestic triangle that we sketched in our first talk. The child and his mother and his father constitute the

first triangle that a human being encounters. Faulty solution of this triangular situation may cause the fears (phobias) which are psychologic mechanisms to express fear resulting from one of these relationships, now projected upon some outside object. If a child is really afraid of dogs, this fear should lead us to an interest in his triangle situation. Where is he in relationship to his father? Where is he in relationship to his mother? The understanding that Freud gave belongs to everyone. If this can be brought into consideration, it becomes understanding for any doctor, for any teacher, and not just the property of the psychoanalyst. We can understand a child's irrational fears through the insights of a psychoanalytic understanding of his situation. Without giving any pronouncement to a parent, but rather asking the parent, "What is Johnny's relationship with you? What is Johnny's relationship with his father?" we may find some things going on that should be modified. Once modified, the fears may melt away.

Sleep problems can be discussed on this level, too. The approach to enuresis in an older school-age child is through learning about his today and his yesterday. What are his feelings about himself as a boy? How does his mother respect him or accept him as a boy? How does his father help him to be like him? Is he someone that the boy can be like, or is the father so rejected by the mother that he cannot be like his father because to be like him is to be rejected. These answers are not so difficult to determine. The male physician gets some of the feeling tones from the mother of his boy patient. Is this a woman who has difficulty relating to a man; does she have to control the man? Enuretic boys usually have pretty controlling mothers. It seems to me that a male pediatrician will feel this situation in the presence of such a woman. If you could say to yourself, "I wonder what it is like to be her son?" many ideas would come to you. You cannot get angry at her (then you are merely doing what the son is doing), but you can feel yourself in the situation of this boy. You can meet the father and see how often he is just exactly as you thought he would be because you know this woman would only marry this kind of a man. Then you say to yourself, "Well now, how is this boy supposed to grow up to be a boy? Where is he going to find a man who is not this kind of a man who is controlled and led around by a woman?" Then ideas come to you about where you can find such a man. You cannot replace the father, but you might help to strengthen him. You cannot castigate him for being passively controlled by his wife, but you can look for some indication that he wants to play a more aggressive role in dealing with his son. He wants to have a greater strength in the family constellation than he has, and you can say to him, "Yes, you have a right to do something," and you can, perhaps, help him to do this in a constructive way.

There are other men than the father in a boy's life, and the pediatrician can help a family to the use of other resources. Using yourself in relationship to your patient, you may be the other man in a boy's life, a man who is not controlled by his mother, who is not rejected, who is not a man who feels inadequate. You are giving him a chance to identify with you as you get to know him. Whatever time you spend with him is spent with him and is not controlled by his mother. Maybe he is old enough to take a bus and come to your office alone, and you plan his visit, respecting his time and yours. You never know what a deep significance there may be in something that looks simple and superficial and may take only 20 or 30 minutes every other week.

There are problems that are closely related to the truly social situation, school problems, particularly social group school problems. Examples are the child who feels, and is, left out of things, and who is afraid to take a chance, who cannot get into happy relationship with his peers, and the child who is actually withdrawing and sits by the sidelines, watching, but afraid to join. We see patterns and we notice how early these patterns are laid down. The nursery school teacher tells us about a child in the preschool age with such a concern for failure with its consequent loss of love that he will not venture. Better play it safe and do nothing. This is something to which a pediatrician can be quite sensitive in his office or on a visit to the home. The overly conforming and the overly good preschooler is not suddenly going to be constructively venturesome and resourceful. Much more likely is he to remain playing it safe. This may be right under our eyes in pediatric practice, and some of the mothers of such children get pediatric pats on the back. The thing that we praise them for, perhaps because it makes our role as a physician easier in the short term view, is the most neurotic adjustment upon the youngster who is our patient. We have to watch ourselves so that we do

not condone this behavior, that we do not give pats where they are not deserved. Does the child's overpoliteness or cleanliness deserve a pat on the back? Or does this, rather, demand some kind of questioning such as "I wonder if this is really as important as it seems to be to you. Let's think about this and let's look at it a little closer." This approach may be more helpful in the long run.

Tics can be included here—the habit spasms in children, the throat-clearing, eye-blinking, shoulder-hitching tics that are so annoying when do we treat tics? They are almost always in the eight to 10 year old and usually in boys. Why should this be? What is going on in this age period? What are children supposed to be doing when they are between eight and 10? Why might it be harder for boys than girls?

Schoolagers are supposed to be doing much conforming, contributing much live muscle activity, exhibiting many impulses to do things for the sake of becoming socialized and civilized children. Sometimes the course is difficult and the discharge of motor pattern comes out in repetitive, meaningless habit spasms called tics, which cannot be stopped by telling a child to stop, but which can be modified if we can see in what kind of squeeze this child is involved. Why does he have to have this tic? It is not at all which tic he has, but rather why does he have a tic?

The kind of tic has something to do with behavior that was meaningful at some prior time. There is a reason why one child has an eye tic and another child has a throat tic. Something was going on once in some of his yesterdays that was a great significance. Let us take eye blinking: previously he saw something that stirred up much feeling; he wanted to see this and yet he did not want to see it. The eye blinking represents wanting to see and also denying what he has seen, or not wanting to see. A tic developed because he is under some pressure in school or at home. He may pick this particular kind of tic because it is tied up with his important emotions in his yesterdays somewhere. A child has a throat-clearing tic. This was probably meaningful, purposeful throat clearing when he had a reason to clear his throat, in terms of an infection, but at the same time emotions may have been stirred up around fear of dying, fear of loss of parents, hospitalization, and the like. We do not know what it was and we may never find out what it was in his yesterday; it is not always important to try to find out what it was. Take it from where you see it and say, "This is a child who is tense and uneasy inside himself. What is going on today that makes this behavior necessary?" Then, when you have found some of the things that contribute to this tension and finding ways of releasing it, the tic has a good chance of disappearing without your ever finding out why he happened to have the eye blinking or shoulder hitching.

The problems of adolescents deserve some mention. Is the complained of behavior something that goes deep in the child's psychology, or is it forced upon him by society or his parents, in terms of how things are set up? Let me tell you about a young adolescent I saw a few weeks ago: He was a 15 year old boy. His parents were most ambitious for him socially, wanting him to go with all the children of their friends, and to do all the things that these young people were doing. Nevertheless, they were giving him the same allowance they gave him when he was seven, and the amount had nothing to do with their finances because they could give him any amount of allowance they wanted to give him. To make it even more difficult for the youth to understand, his parents spent tremendous amounts of money on him in other ways and on themselves. When it came to an allowance, he got 50 cents a week. Money had some meaning to them in terms of the freedom that they were afraid to give him. If they gave him money, it would make certain activities possible. Without it, they thought they were controlling him.

What these parents did not realize was that they were making it necessary for the boy to steal or borrow or to withdraw from the social contacts which he wanted and which they wanted him to have. He had not stolen yet, but he had borrowed, and he was afraid to let on where he had been because he would get the "third degree" as he put it. He could not tell them he went to a movie with a friend and two girls and stopped off for a hamburger because he would immediately expose his borrowing or be accused of stealing. His parents would know he could not do this on 50 cents a week. He had not run away yet, but he had refused to discuss what he did on dates, and his parents worried because they had no clue as to what was going on. It does not take a psychiatrist to understand this situation. Any family physician, any pediatrician, could handle it. The complaint that the parents

brought with them was, "He doesn't tell me anything. I can't get close to him, and he stays in his room all the time. He goes out and comes in, and we never hear what he has done."

The referral came to me because the pediatrician thought this boy was beginning to show some serious personality changes, and his physician was scared to deal with adolescents anyhow. He certainly did not want to deal with one when he considered him an incipient schizophrenic. This was a most interesting case, and it had many ramifications. Any pediatrician should have been able to handle it because 10 minutes with this boy told the whole story: he was still being treated at 15 exactly as he was treated when he was seven and he had to behave just as he was.

Now our time is up and I would like to read a poem. I wish I could say I wrote it, but it is anonymous. It is called "The Lament of the Normal Child."

I was strolling past a school house, when I spied a sobbing lad,
His little face was sorrowful and pale.
"Come tell me why you weep," I said, "and why you seem so sad,"
And thus the urchin lisped his tragic tale:
"My school you know is a modern school with numerous modern graces
And there they cling to the modern rule, 'Cherish the Problem Cases.'
From nine to three I develop me, I dance when I'm feeling dancy,
Or I lay on with my crayon the colors that suit my fancy,
But when the commoner tasks are done, deserted, ignored I stand,
For the others all complexes have, or a hyperactive gland.
Ah, how can I ever be reconciled to my hateful normal station?
Why couldn't I be a problem child, endowed with a small fixation?
Why wasn't I trained for a problem child, with an interesting fixation?
I dread the sound of the morning bell. The iron has entered my soul,
I'm a square little peg who fits too well in a square little normal hole.
For seven years in Mortimer Sears has the Oedipus angle flourished,
And Jessamire Gray, she cheats at play, because she is undernourished.
The teacher beams on Frederick Knipe with scientific gratitude.
For Fred, they claim is a perfect type of the antisocial attitude.
And Cuthbert Jones has his temper riled in a way professors mention.
I'm nothing at all but a Normal Child, so I don't get the least attention.
The others jeer as they pass me by. They titter without forbearance
He's perfectly normal they swiftly cry, With perfectly normal parents.
For I learned to read with normal speed; I answer when I am commanded.
Infected antrums don't give me tantrums, I don't even write left-handed
I build with blocks when they give me blocks; when it's busy hour, I labor
And I seldom delight in handing socks on the ear of my little neighbor.
So here, by luckier lads reviled, I sit on the steps alone.
Why couldn't I be a problem child with a case to call my own?
Why wasn't I born a Problem Child with a complex all my own?

Children's Hospital.

Epidemic Neuromyasthenia, An Outbreak In Punta Gorda, Florida

An Illness Resembling Iceland Disease

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In the spring of 1956, there appeared in the south Florida community of Punta Gorda a bizarre disease previously unknown to those of us there. The illness was characterized principally by pronounced fatigue; pain in the head, neck, and extremities; nausea and vomiting; dizziness; paresthesias; emotional lability and depression; impairment of memory; and a protracted, relapsing course.

A major epidemic composed of cases of a strikingly similar nature was observed in Tallahassee in the fall of 1954.[1] Additional outbreaks in Florida were reported from Bradenton in the fall of 1955,[2] and from Lakeland in the fall of 1952.[3] In recent years, reports of similar epidemics have come from many parts of the world[4] and from points in this country as divergent as southern California[5] and upper New York state.[6] In England, similar illnesses have been commonly called "benign myalgic encephalomyelitis,"[7] while in this country, the term "Iceland disease" has found greater favor.

The high attack rates experienced among populations affected and the protracted debilitating course of the illness serve to produce a situation commanding the interest and concern of the practicing physician.

Punta Gorda Outbreak

In retrospect, the epidemic in Punta Gorda appears to have commenced in February of 1956. Cases initially were infrequent. Anxiety and depression evidenced by the patients, the nonspecific symptomatology, the multitude of symptoms and contrasting relative absence of positive physical and laboratory findings, and the frequent occurrence of cases among middle-aged women readily served to obscure diagnosis and identification of the existence of the epidemic in its initial phases. "Neurosis" was the usual case diagnosis, not inconsistent with the findings and an initial diagnosis commonly made in other epidemics.

By late April, the appearance of larger numbers of cases and the failure of recovery among earlier cases produced increasing concern in Punta Gorda and the recognition of the need for a major community-wide study. Assistance was sought, and in May investigations were initiated by the Florida State Board of Health and the Charlotte County Health Department. Additional support was subsequently provided by the Public Health Service's Communicable Disease Center.

Cases continued to occur throughout May with the peak occurrence of cases coming during the first week. The appearance of new cases fell rapidly thereafter and ceased by the first week in June.

Symptoms

Initial studies were focused on a better definition of the illness. Twenty-one patients who reported being currently ill were selected for detailed clinical and laboratory study. Seventeen of them were female; all were white. They ranged in age from 14 to 60 years.

The onset in most was insidious, marked by gradually increasing fatigue, headache, and pain in the neck, back, and extremities. Commonly, dizziness, emotional tension, depression, and some mental confusion commenced soon after the onset. In about half, there was a pronounced, abrupt exacerbation of symptoms between one and four weeks after the onset. The progressive course of the disease is reflected by the fact that, among 19 of this group who became bedridden, the median time between onset and confinement to bed was 19 days.

Figure 1 depicts the relative frequency of the more common symptoms. Fatigue was the most incapacitating symptom in terms of frequency and

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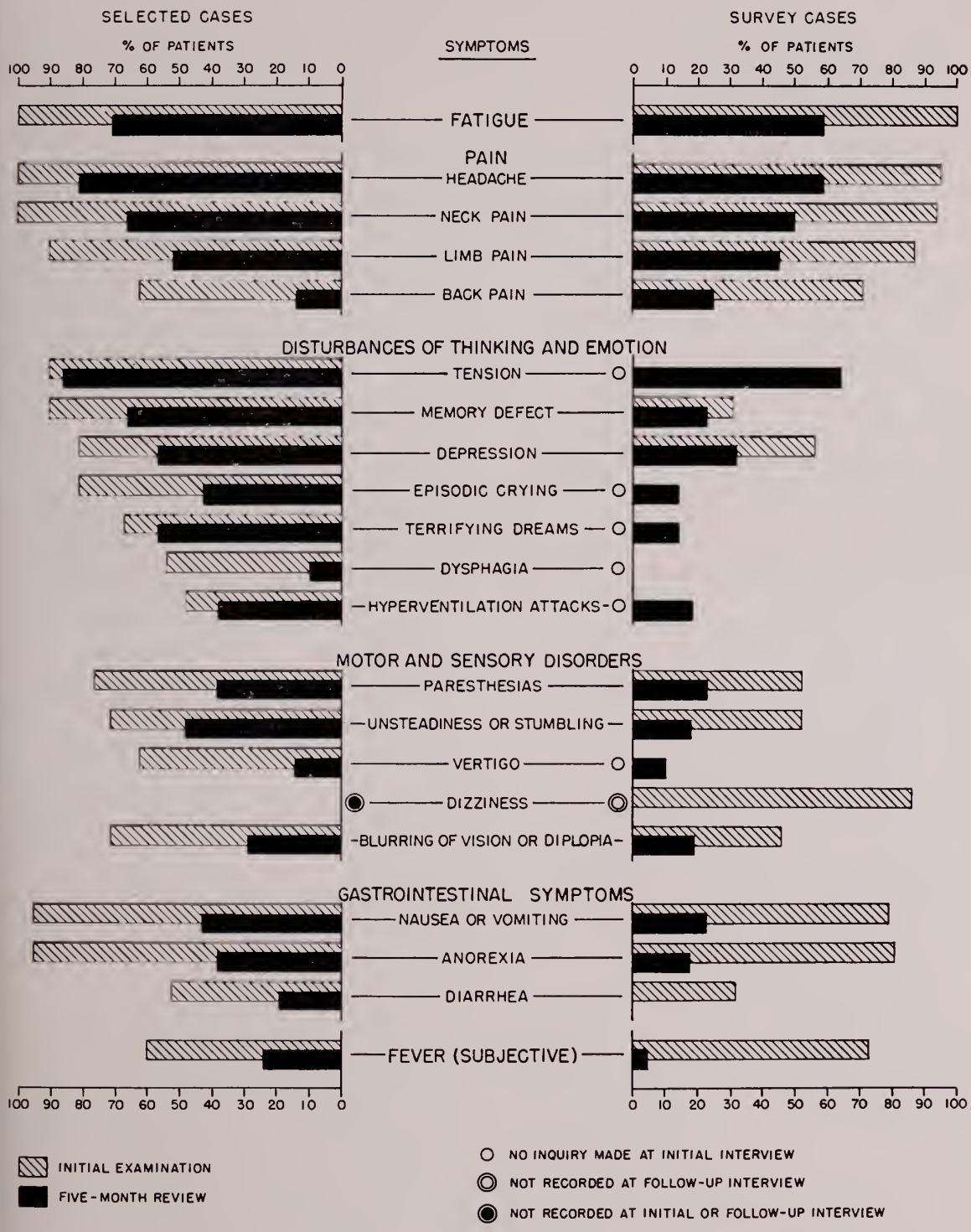
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FIGURE 1

FREQUENCY OF OCCURRENCE OF SYMPTOMS



DHEW-PHS-BSS-CDC ATLANTA, GA.- JAN., 1957

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persistence. Headache was, in general, poorly localized, nonthrobbing in character, and little relieved by analgesics. Severe occipital or suboccipital pain radiating toward the frontal area was common. Limb and back pains were similar in nature in each of the areas, being described as aching in quality, "deep" and "diffuse."

Emotional changes were particularly notable. Anxiety and depression were reported by almost all patients. Episodes of crying without provocation and frequent terrifying dreams were common. Difficulty in recalling recent events was reported by many. During the acute phase particularly, a number of patients noted a tendency to transpose letters when writing or words when talking. Two symptoms customarily referred to as neurotic were encountered with unusual frequency. These were hyperventilation attacks and dysphagia without regurgitation.

Paresthesias, assuming the form of numbness and tingling of the extremities, were reported by most patients. Paresthetic areas were patchy, however, and not infrequently shifted from week to week. No nerve or root pattern for these could be discerned.

Unsteadiness or stumbling was primarily subjective and not particularly evident to observers.

Anorexia and nausea, often with vomiting, occurred in almost all patients. Vomiting in a few became severe enough to require intravenous fluid therapy. In many cases in which there was severe vomiting, patients reported symptoms consistent with vertigo.

Feverishness was reported by 13 of the 21 patients. On but five occasions were readings in excess of 100 F. noted. The temperature elevations rarely exceeded one day; the highest recorded temperature was 102 F. Menstrual irregularities, irregular periods or amenorrhea, were common.

Although emotional changes were overtly evident, objective physical findings in the patients were wholly disproportionate to the severity of their illnesses. A sensation of neck "tightness" resembling a mild nuchal rigidity was experienced by most patients when the neck was fully flexed. Reflexes were equal bilaterally although sometimes accentuated.

Mild to moderate impairment of touch, pain, and temperature in varying combinations were present in 12 patients. Distribution of the abnormalities, however, did not conform to the distribution of root or peripheral nerve zones.

Focal muscle tenderness, that is, areas about 5 to 8 cm. in diameter, were present in nine patients. A mild paresis was present in two although many more complained of real weakness. A Romberg sign was noted in five.

Laboratory studies revealed little. White blood cell counts and cerebrospinal fluid examinations performed were normal. Stools, throat washings, blood clots, and spinal fluids were tested by inoculation of suckling mice, HeLa, monkey kidney, and human liver tissue culture systems at the Virus and Rickettsia Laboratory, Communicable Disease Center. Despite two and three blind passages with many of the specimens, no agent was isolated. Bacteriologic cultures of stool specimens were negative. Paired serums from 12 patients were tested for antibodies to the arthropod-borne encephalitides, lymphocytic choriomeningitis, brucella and leptospira. These were all negative. Heterophil determinations were also negative.

From study of these 21 patients, certain problems became apparent. We appeared to be confronted with a disease of protean symptomatology with relatively few physical findings. There apparently was no individual symptom or constellation of symptoms specific enough to permit conclusive case diagnosis, and most perplexing was the observation that cases in less severe form blended increasingly with psychoneurotic illness.

Epidemiologic Characteristics of More Severe Cases

Recognizing then that for epidemiologic study, minor cases would necessarily have to be discarded, we formulated criteria which in this outbreak would include the more pronounced cases and more certainly exclude psychoneurotic illness. The criteria were as follows:

1. A definite change in physical and emotional status indicating an onset of illness during the epidemic period
2. Illness of seven or more days
3. Presence of at least six of the common symptoms

The epidemiologic characteristics to be presented are descriptive then only of the more severe cases.

A house-to-house survey was organized, in which half the population of Punta Gorda was sampled. Sixty-two cases were uncovered, which met the noted criteria. From the survey, it was apparent that at least 120 relatively severe cases had occurred in addition to a substantial number

of less severe cases. The comparative frequency of symptoms for this group as compared to the selected case group is included in figure 1. In general, the pattern of occurrence of symptoms is similar in the two groups although the frequency is somewhat reduced in the survey group, indicating an over-all less severe illness.

In table 1 are shown the age-specific attack rates for the survey cases. Notably absent are cases among children under 10 years of age. Our youngest patient actually was 12 years old. Despite intensive questioning of parents, we were able to uncover little illness of even a minor nature among children during the epidemic period. The attack rates for Negroes are based on small numbers and do not deserve further comment. Attack rates for white females are relatively constant through age 69. The males show a relatively similar rate through age 49, after which there is a substantial decline.

Despite the rather similar rates among males and females under the age of 50, it was the impression of all that the disease, though present, was less severe in the males.

Table 1.— Attack Rates by Age, Sex, and Race
House-to-House Survey
Punta Gorda, Florida

Age Group	White Female			White Male			Negro Female			Negro Male			Total		
	Cases	Pop.	Attack Rate (%)	Cases	Pop.	Attack Rate (%)	Cases	Pop.	Attack Rate (%)	Cases	Pop.	Attack Rate (%)	Cases	Pop.	Attack Rate (%)
0 - 9	0	51	—	0	62	—	0	19	—	0	18	—	0	15	—
10 - 19	6	56	10.7	5	46	10.9	0	18	—	0	23	—	11	143	7.7
20 - 49	15	131	11.5	11	121	9.1	4	36	11.1	1	26	3.8	31	314	9.9
50 - 69	10	110	9.1	3	106	2.8	4	25	16.0	0	17	—	17	258	6.6
70 & over	2	35	5.7	0	45	—	1	8	12.5	0	5	—	3	93	3.2
Unknown	0	16	—	0	23	—	0	8	—	0	5	—	0	52	—
	33	399	8.3	19	403	4.7	9	114	7.9	1	94	1.1	62	1,010	6.1

Follow-Up Study

Five months after our initial visit to Punta Gorda, we interviewed and re-examined the same 21 patients initially intensively studied. They had shown slow but definite improvement interrupted by a series of exacerbations. Recurrence of symptoms seemed to be associated particularly with excessive fatigue or occurred with the onset of the menstrual period. Anxiety, depression, fatigue, and insomnia were most disabling of the symptoms persisting. A random sample of the survey group was similarly interviewed. This group was, on the whole, less disabled but experienced a similar persistent pattern of symptoms.

The emotional and physical debility evidenced by those in Punta Gorda six months after the onset of their illness was distressing. But two of 21 experienced asymptomatic days by the sixth month of illness. Five of this group had been confined to bed for one or more days as late as the sixth month following onset, two of these being confined to bed for the entire month. In over 40 per cent of the total patient days during the sixth month definite restriction of activity was necessitated because of symptoms. Additional follow-up studies on these patients would be of considerable interest.

Many possible vehicles of transmission were investigated, including water, milk, various foods, cosmetics, soaps, and insecticides. None could be incriminated. Mosquitoes were reported as absent from the community until an influx on April 21.

Geographically, cases appeared to be limited to Punta Gorda and the rural area within a nine mile radius. Discussions with physicians in neighboring towns uncovered no cases in the adjacent communities.

Because of several reports which have appeared of outbreaks of a similar disease entity among hospital personnel, a survey was made of medical and allied personnel in Punta Gorda. This group constituted 38 persons in all. Applying the same case definition criteria to this group as were applied in the survey, 16 cases were uncovered. The attack rate for this group was 42 per cent, far in excess of that experienced by the town as a whole.

Discussion

The studies outlined illustrate certain of the difficulties encountered in the study of this disease entity. With no deaths occurring during this epidemic and none recorded in other epidemic situations, a pathophysiologic explanation for the symptoms remains obscure. There are no classical signs or symptoms to permit conclusive diagnosis in the individual case. Laboratory studies have to date proved negative. The similarity of symptoms to those of anxiety reaction and neurosis of various forms served to make the recognition of individual cases difficult. For these reasons, the positive diagnosis of cases must, we believe, be yet confined to the endemic situation.

Common factors between the separate reported epidemics include prolonged debility, symptoms of fatigue; pain in the head, neck, back and extremities; nausea and vomiting; and emotional disturbances of greater or lesser severity; a virtual absence of fever; a paucity of physical findings; and a lack of abnormal laboratory findings. Epidemiologically, the confinement of cases to adolescent and adult patients and the significantly greater severity of cases among women are central to, and mandatory for the diagnosis.

It should be emphasized that the clinical picture presented in Punta Gorda will, in all probability, not present identically elsewhere. As each of the epidemics is reviewed in detail, it is apparent that there is a similar but not identical clinical and epidemiologic pattern of illness. In symptom detail and in over-all severity, there are clear differences.

Noteworthy, in contrast to the epidemic in Punta Gorda, was that which occurred in Tallahassee. Without question, this latter outbreak was more severe, the illness even more prolonged, and the sequelae more disabling.

Conclusion

The need for further investigation of subsequent epidemics is apparent. Care must be exercised to avoid overdiagnosis and the use of the illness as a "wastebasket" for wholly unrelated psychoneurotic problems. On the other hand, failure to diagnose and to recognize this illness in its epidemic form may be equally damaging.

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133 West Marion Avenue (Dr. Clement).

Perforation of the Interventricular Septum Due to Myocardial Infarction Diagnosed Antemortem

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Miami

Rupture of an interventricular septum due to myocardial infarction has been reported previously, usually diagnosed initially at autopsy. The antemortem diagnosis is not too commonly made.[1] As the patients may survive for several months or years,[2-4] the importance of an accurate diagnosis is manifest, since surgery is now successfully attacking interventricular defects and should be more successful in the future. For these reasons, a case of ruptured interventricular septum following acute myocardial infarction is reported.

Report of Case

A 44 year old white man was admitted to Mercy Hospital on June 13, 1956, with moderately severe substernal pain which had persisted for four hours. The history revealed several attacks of pain of similar type lasting five to 10 minutes during the past month. The electrocardiogram was compatible with acute myocardial infarction of the anterior wall. The patient was given aqueous heparin every six hours for three doses, and Coumadin by mouth was begun. Pain was incompletely relieved by Demerol and morphine.

About 36 hours after the onset of pain, the patient was pale and perspiring freely. The blood pressure had dropped from 160 systolic and 120 diastolic to shock level. After a bout of syncope, the heart rate decreased from 120 to 64. The electrocardiogram revealed right bundle-branch block.

The blood pressure was maintained with Levophed, and left ventricular failure was treated by digitalization and diuretics. A precordial friction rub had become audible. Several convulsions occurred lasting about 30 seconds each.

During the subsequent days of hospitalization, the patient's condition improved. Substernal pain recurred on several occasions. On the twelfth day of hospitalization, while sitting on a bedside commode, the patient experienced severe substernal pain radiating into the neck. When seen a few minutes later, he was in shock. A grade III systolic murmur had appeared which could be heard over the entire precordium. A thrill could now be felt over the precordium. Rales appeared in both bases; the liver had become palpable. Pressure on the liver caused distention of neck veins. A diagnosis of rupture of the interventricular septum secondary to acute myocardial infarction was made, and the patient was treated for shock. Death, however, occurred two hours later.

Autopsy Findings.—The significant pathologic changes were limited to the heart. The pericardium and epicardium were both covered by granular, fibrinous tissue and were blood-stained. Friable adhesions on the anterior surface of the epicardium were present. The heart weighed 400 Gm. On cut section, a large area of softening and yellowish discoloration involved the entire width of the inferior three-quarters of the interventricular septum. This area of necrosis extended for a short distance into the anterior wall of both ventricles. A perforation of the interventricular septum that measured 3 cm. in diameter was identified. This perforation was located at the distal pole of the septum adjacent to the anterior myocardial wall.

A gray, firm thrombus occluded the lumen of the left anterior descending coronary artery in its proximal portion. Moderate arteriosclerotic degenerative changes were present throughout the coronary arteries and the aorta.

Microscopic Findings.—Microscopic examination of the heart revealed a diffuse hemorrhagic epicarditis and severe arteriosclerotic narrowing of the left anterior descending coronary artery. Massive acute necrosis and thinning of the myocardium were present, both in the involved area of the interventricular septum and the anterior left ventricular wall. In the region adjacent to the area of perforation, the normal myocardium had been replaced by a weak wall of edematous granulation tissue and isolated islands of degenerated myocardial fibers.

Discussion

This patient presents the characteristic murmur and thrill associated with right-sided failure. Frequently, however, septal rupture is confused with rupture of a papillary muscle.[5] The latter is not as commonly associated with a thrill, the murmur is located more laterally, and death usually occurs in a few hours. The pathogenesis of rupture of a papillary muscle is excessive strain on the necrotic muscle.

The question of strict bed rest versus mobilization and their effect on septal perforation arises. Cardiac rupture is an early complication[1] of myocardial infarction, and strict rest should be emphasized in the first week after infarction or until the diagnosis is unquestionable. Perforation apparently occurred in our case after straining while the patient was on a commode.

Septal rupture is usually heralded in by sudden deterioration of the patient's condition evidenced by pain, dyspnea, tachycardia, signs of right-sided and left-sided failure, and shock.[6] This change, accompanied by the appearance of a harsh, systolic murmur heard best at the apex, lower sternum, or left fourth intercostal space, associated frequently with a thrill, should lead one to the diagnosis of perforation.

If the patient survives any period of time, cardiac catheterization should be performed to confirm the diagnosis with the view in mind that surgical intervention and repair be carried out.

Summary

A case of septal perforation due to myocardial infarction diagnosed antemortem is reported.

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ABSTRACTS

Sexual Precocity Due to Interstitial-Cell Tumor of the Testis: Report of 2 Cases. By Edwin C. Jungck, M.D., Agatha Moody Thrash, M.D., A. P. Ohlmacher, M.D., Arthur M. Knight Jr., M.D., and Lucien Y. Dyrenforth, M.D. J. Clin. Endocrinol. 17:291-295 (Feb.) 1957.

A functioning Leydig cell tumor of the testis arising before the age of 10 years is a rare entity. Two cases of precocious pseudopuberty due to interstitial cell tumor of the testis are here reported, bringing the total number of such cases reported in the world literature to 20.

The diagnosis of this condition depends on the concomitant finding of sexual precocity and unilateral testicular enlargement. Since the puberal changes are limited to those produced by androgen alone, the condition is differentiated from true precocious puberty in that the spermatogenic function of the testis is dormant. Thus, the unaffected testis remains infantile. The enlargement in the involved testis consists of a small mass of atrophic tubules and a tumor composed of masses of interstitial cells. The condition must be differentiated from precocious pseudopuberty secondary to an adrenal masculinizing tumor, in which both testes remain prepuberal in size and a tumor of the adrenals or an aberrant adrenal cell rest is present.

Treatment consists of excision of the involved testis. The chief problems in this type of precocious puberty are the excessive growth and the strength of the children, the pronounced acceleration of bone maturation with eventual adult drawfism, and the possible sexual disturbances. The patients in the two cases reported showed remarkable growth and strength, and in one instance the boy's aggressive character and social immaturity were such that he became a delinquent and was sent to a reformatory. Within a year after removal of the tumor, he was rehabilitated.

Chloramphenicol-Tetracycline Treatment of Salmonellosis in Children. STRIP-GRADIENT AND REPLICA STRIP-GRADIENT TECHNIQUES AS GUIDES TO THERAPY. By Murray M. Streitfeld, Ph.D.; Milton S. Saslaw, M.D., and Robert B. Lawson, M.D. A. M. A. J. Dis. Child. 94:155-168 (Aug.) 1957.

The study reported here records the bacteriologic and clinical findings in a series of patients suffering from salmonellosis. Strip-gradient studies performed on 45 species and strains of salmonellae demonstrated the in vitro efficacy of combined use of chloramphenicol and tetracycline in inhibiting growth of these organisms. The 45 strains consisted of 29 isolates from stool or blood cultures from patients ill with Salmonella infections, including five patients with typhoid fever, one isolate from a rat colony epidemic of pulmonary and gastrointestinal salmonellosis, and 15 stock strains of different groups and types of salmonellae. Replica strip-gradient investigations indicated that the effects of the combined antibiotics were bacteriostatic rather than bactericidal.

These in vitro results were used as guides to therapy in 11 human patients, two with typhoid fever and nine with other types of salmonellosis, who had failed to respond adequately to prior medication with single antibiotics or combinations other than chloramphenicol and tetracycline. The combination of chloramphenicol and tetracycline

was uniformly additive or synergistic in vitro and almost uniformly effective therapeutically. This treatment is discussed from the standpoint of correlations of in vitro observation with in vivo application, but no conclusions can be drawn because of the small number of patients treated. The authors believe, however, that their findings warrant further clinical trial of this antibiotic combination.

Rupture of the Marginal Sinus of the Placenta. By James Henry Ferguson, M.D., J. A. M. A. 166:476-478 (Feb. 1) 1958.

Rupture of the marginal sinus of the normally located placenta is one of the most frequent causes of bleeding in the last trimester of pregnancy, as observed on the Tulane service at the Charity Hospital in New Orleans and at the Jackson Memorial Hospital-University of Miami. There is a growing appreciation of its existence. It is not particularly dangerous for the mother or baby. Rather, its importance lies in the necessity of differentiating it from abruption, low-lying placenta, and minor degrees of placenta previa so that these diagnoses can be more accurately cataloged. In particular, a clearer picture of abruption should emerge from a wider understanding of rupture of the marginal sinus. The author explains that the diagnosis of rupture of the marginal sinus of the normally located placenta depends on a demonstration at the margin of the placenta of a clot that is continuous with clotted blood in the marginal sinus. At the same time, it must be demonstrated that the clot had not interposed itself between the uterus and the placenta.

Skeletal Head Frame: A Preliminary Report. By Edward L. Flynn, D.D.S., Reginald G. Standerwick, B.S.E., and Mason Trupp, M.D. J. A. M. A. 167:442-443 (May 24) 1958.

Surgeons familiar with the treatment of maxillofacial fractures are aware of the inadequacy of the present method of plaster head caps in obtaining an extraoral point of fixation for reducing and immobilizing fractured bones. In order to overcome the disadvantages of this method and to provide the necessary extraoral point of fixation frequently required in the management of maxillofacial fractures, the authors (an oral surgeon, a neurosurgeon, and a developmental engineer) designed a skeletal head frame, which is here described. It consists of an aluminum frame comprising three curved channel bars and finely turned, adjustable, stainless steel spade drills. Placing the head frame takes about 15 minutes. In a series of 15 cases this device offered distinct advantages, which are enumerated. The authors believe that it represents a real milestone in the ever advancing search for improved orthopedic maxillofacial and neurosurgical appliances.

Tinea Nigra Palmaris: A Disorder Easily Confused with Junction Nevus of the Palm. By J. Graham Smith Jr., M.D., Wiley M. Sams, M.D., and Frank J. Roth Jr., Ph.D. J. A. M. A. 167:312-314 (May 17) 1958.

Tinea nigra palmaris is an uncommon skin disease caused by the fungus Cladosporium Wernecki. Only five cases acquired in the United States have been reported although the disease has been reported from elsewhere in the western hemisphere. The first of these five cases was that of a 15 year old girl from Tallahassee; the other four were all seen within one year in Texas. The observation of two more cases of tinea nigra occurring at widely separated parts of Florida suggested that the disease may be more common than generally appreciated and led to this report, since both of these cases were mistaken clinically for junction nevi. One of the patients was 55 years of age, the first in whom this disease has been reported in the United States in a patient over 12 years of age. The disease is banal, asymptomatic, and responds readily to local therapy with keratolytic agents. The macular lesions, neither elevated nor scaly, are brown or black, appearing like an India ink or silver nitrate stain, and must be differentiated from nevi, contact dermatitis, pigmentation of Addison's disease, and drug eruptions. Attempts at experimental reproduction of the disease by inoculation of infected scales and the fungus itself into the epidermis of human volunteers were unsuccessful.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

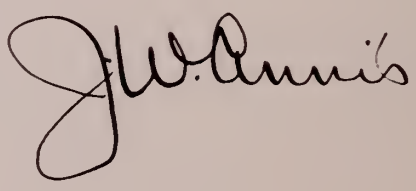
Scientific Program for 1959 Annual Meeting

Welcome back from vacation—back to the routine and the increased tempo of medical practice in our busy season— and back to the start of another season's chain of academic, professional and educational events—the specialty group conclaves—the interim meetings—the Southern Medical, et cetera. All loom in the near future and serve to get us back into the atmosphere of academic interest, scientific advancement and research that is proper to us as physicians and—I hope—as scholars. All this is one of the reasons which justify our existence.

Most of us this fall or next spring will attend these meetings, and this is good—but all too few of us will actively participate in them through the presentation of papers or discussions—and this is bad. We have a responsibility to our colleagues, to our patients and to ourselves, that we can fulfil only by engaging in this continuing process of medical education—only by critically evaluating our experiences, tabulating them and presenting these data publicly, so that our conclusions may be discussed—challenged and accepted or rejected by others in our field. It is through such effort that Medicine progresses and that the minds of its physicians are kept pliable—active—and keenly progressive.

As you will note elsewhere, the deadline for submission of abstracts of papers to be presented at the Eighty-Fifth Annual Meeting of the Florida Medical Association next May is November 1. This scientific program is your first obligation in the field of medicine. It is your program and reflects—to the state and the nation—your excellence or your mediocrity professionally. It is designed as an outlet for the scientific expression of the physicians of Florida and depends for its success upon the active participation of the excellent medical talent of this state. By the papers presented here are we known elsewhere. Think well on this and on your share of the responsibilty toward maintaining our professional standards and reputation.

Send an abstract of the paper you can present with the pride of accomplishment to our Scientific Work Committee, Box 2411, Jacksonville 3. It will do you good.



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The Team Doctor

Athletic Injuries

On the "team physician," or any doctor who handles athletes and their injuries, rests the prime responsibility of checking the athletes he attends to make sure that they are physically fit before entering into a sport. His other major duty is to treat those who suffer injury as a result of their sports participation.

The doctor does not always have the opportunity to check the participant before he engages in sports activities. Such a program would, however, be most helpful for it would insure that all participants would be able physically to withstand the strain and stresses of the activities. Those found unfit could be duly conditioned for athletics with proper programming of exercises. This plan would cut down injuries resulting from illness or physical unfitness.

Many an injured player or a person who is not always in the best of physical condition hides himself from the physician since he is afraid that an examination would prevent his sports participation. This attitude represents a misconception of the idea of a team doctor. He is not one who keeps people from playing, but instead helps them to attain the proper physical status for participation. This approach not only holds true for the examination before participation but for evaluation of injuries. In no instance does the doctor think first of the team. Allowing a physically unfit person to participate would not only subject this player to injury, but might even be detrimental to the other players of the team since they would not have the support they believe to be present.

Not all injuries require the side lining of a participant. Such injuries as a sprained ankle can frequently be adequately taped or supported to allow the injured to participate without danger of suffering further injury. In many programs of athletics, it is not unusual for all the participants to apply strapping or bandaging to an ankle or knee to help protect it against injury just as the football player applies pads to different parts of the body that will come into physical contact. Such a program of prophylaxis along with the preparticipation examination would help tremendously to cut down to some degree the number of injuries. In the participation of the sport, many

rules and regulations are usually drawn so as to deter such actions as might cause physical violence to the opponents. This precaution is commonly seen in football where the clipping motion calls for a penalty as well as the roughing of the passer or the kicker.

Of course, once the player has been injured, it behooves the doctor to make sure that his condition improves sufficiently to allow him to participate again without danger to himself. A slightly pulled muscle in the wrong place would cause continuing or even disabling injuries if this muscle were not allowed to heal properly. It is not uncommon for a mild back sprain to be neglected only to have the back seriously injured by the next encounter and thus disable the person for a longer time than would have been the case had he been initially side lined and treated until the injury had healed.

Knee injuries should be particularly studied. It is not unusual for a knee injury to be a serious ligamentous tear and initially considered something minor. Early diagnosis and treatment frequently allow much better results than delayed treatment. There is also the danger of recurring injury in the absence of adequate protection or side lining of a participant with such an injury.

The team doctor has a major responsibility in the care and development of the athlete. He should acquaint himself as far as possible with all the problems of preventing, as well as treating, sports injuries.

GEORGE I. RAYBIN, M.D.

Committee on Scientific Work Urges State Program Applicants to Heed November 1 Deadline

Three hundred and one years ago the Jamestown colony was founded. Forty three years earlier, the Spanish had established themselves here in Florida. For more than 150 years, reflecting the European mother countries, medicine in America developed little more than purge and phlebotomy technics. The scientific renaissance, though developing rapidly, had not yet shown more than a few isolated instances of brilliance in the New World.

Even in colonial days, however, the doctor, the priest or minister, and the law, as represented by governor or representative of governors, were the leaders in their respective communities. As such, each usually earned and deserved that position of leadership by his education and ability.

Now, we are observing a revolution before our eyes, both politically and socially. This revolution has many facets. No longer can we be assured that the interested parties to these facets in medicine and about medicine have a sincere desire to improve medical care or the distribution or financing of medical care. Often only the goal of political power and prestige is behind a scheme to market our services.

On the other hand, any revolution has its side effects, and in haste or anger or through lack of understanding, the leaders of a group may be annihilated in favor of less competent advisors—such action to be regretted as soon as the revolutionaries have awakened. Consequently, it is our duty as a profession to do our best to maintain our own leaders and wise men.

One of the facets of the present revolution in society is in medicine itself with its changes in education and methods which we are privileged to observe in our own medical schools (September Journal, page 296)—also its changes in scientific content would have staggered the imagination of the wisest practitioner of 200 years ago. These changes parallel in rapidity the developments of atomic science and as such are equally staggering in quantity as well as awesome in their context.

The continuation of self education is not only our best means of keeping up with the developments of medicine but also our first step in maintaining our position as leaders in the community as a whole. This must and should be done by participating in our own program of self education in our own community and in our own state. Not only attending our own society meetings but also preparing scientific material for presentation to our colleagues is a rewarding self education process. Dr. Arthur Hertzler, the "Horse and Buggy Doctor," was heard to say once after being congratulated on his latest publication:

"I thank you for your comments and am happy that you enjoyed the book. Once written

though, I never look at them as that was my way of studying the subject. I find that I was never certain the subject matter was well in hand until I could put it down on paper clearly for others to read."

So, it is a duty to our profession to improve in our own scientific progress, a duty to our community to participate in the problems of non-professional activities, and a duty to our heritage since the days of Hippocrates to maintain ourselves as a profession. If we do not continually seek to do so, first by ever maintaining our scientific leadership in the complex society in which we live today, we shall deserve to be relegated to a segment in the total social unit.

Florida, furthermore, as a state is booming as a center of opportunity for recreation, for industry, for agriculture, and for atomic energy. The need for scientific study and observation in all of these fields is ever present. The population changes resulting from this development are in themselves quite a challenge for study. Little has been done toward the study and solution of the growing problem of the aging segment of the population, particularly of Florida. If these opportunities are kept in mind, a high caliber scientific meeting in Florida should yearly have a backlog of important articles of interest not only to physicians of Florida and the entire Southeast but also to the medical profession at large.

The program for the scientific session at the Association's next meeting, to be held May 2-6, 1959, at Bal Harbour, Miami Beach, will be selected by the Committee on Scientific Work on Nov. 1, 1958. The heart of this annual meeting is the quality of the original papers presented. A place can still be found on the program for presentation of good work. Please note the same plan will be followed as in the past with 15 minutes for the paper and five minutes for discussion. It is emphasized, however, that motion pictures will not be shown on the regular scientific assembly program. They should be confined to the scientific film program. It is technically too confusing in illustrating a 15 minute scientific paper of major importance to switch from 35 mm. slides to 3 ¼ slides, to various size motion pictures. Consequently, please confine motion pictures to the scientific film program.

The scientific exhibits themselves present an opportunity not only for the elaboration of new methods but also for the portrayal of original research. Further, they may be used to review the nuggets of the past whether cultural or historical or purely scientific summaries in broad review. It is emphasized that there will be more than adequate space for these exhibits.

It is expected this year that adequate facilities will be available for scientific motion pictures. Those prepared by our own Florida physicians portraying their current research are expected to be of unusual interest.

The Committee on Scientific Work will review abstracts of papers, exhibits, and motion pictures proposed by members of the Association, select those which seem of most pertinent interest, and arrange them into the program. It may seem early, but remember the Target Day of Nov. 1, 1958, so that your paper on your favorite subject covering your own study, research, and observation, over which you labored so long, is not held over for the following year just because of delay in getting it in in time to be organized into a well knit program.

Revised Medicare Program Now in Effect

Changes in the Dependents' Medical Care Program limiting certain types of care by private physicians and in private hospitals became effective on Oct. 1, 1958. These changes in policy represent an effort by the Department of Defense to comply with its interpretation of the action of the Congress limiting expenditures for the current year to $70.2 million. Last year's expenditures were approximately twice the amount budgeted for this purpose, and the total anticipated costs for the current year would be even higher, reaching an estimated $100 million, if the program were not curtailed. The House originally proposed only $60 million, but on amendment sponsored by Senator Knowland (R., Calif.) the bill as approved increased the total to $70.2 million and lifted the ceiling on spending. If the ceiling had been kept in the bill, the spending would have been limited to $60 million. The situation, therefore, could have been worse. For the present, the Medicare administrators, the doctors and the hospitals can only comply with the instructions of the Congress. Should the situation warrant, the problem could, of course, be returned to the Congress when the new session opens in January.

To cut expenditures by about 30 per cent in order to effect the necessary economy and to

assure optimum utilization of uniformed services medical facilities, the Office for Dependents' Medical Care announced the following restrictions:

RESTRICTIONS ON SPOUSES AND CHILDREN RESIDING WITH SPONSORS. — Dependents living with their sponsors are now required to utilize military facilities if available and adequate as determined by the commander of the medical facility. When these facilities are not available, permits issued by the appropriate military commander will entitle these dependents to receive authorized care from civilian sources at government expense, subject to the new restrictions in the scope of authorized care.

For physicians and hospitals to insure payment of their claims for rendering presently authorized care to this group, a permit is now required, except as follows:

In case of a "bona fide acute emergency" such as serious accidental injury or sudden illness requiring immediate treatment at the nearest available medical facility to preserve life or prevent undue suffering, a statement by the attending physician on the proper form will suffice in lieu of a permit.

A dependent away from the area of the sponsor's household on a trip may receive care from civilian sources with an "On Trip" statement provided on the proper form by the person or entity rendering the care.

A maternity patient in this group who is under the care of a civilian physician on or before Oct. 1, 1958, may continue under his care if she reached the second trimester of pregnancy on or before that date. A statement to that effect by the attending physician on the specified form will suffice when submitted by him and the hospital. There must, however, be no change of physician or of duty station of the sponsor in such cases.

Eligible dependents hospitalized for authorized care prior to midnight September 30 whose hospital care resulting from this admission extends beyond that date need provide no permit, but the hospital and the attending physician must show the date of admission to the civilian hospital on all claim forms.

With these exceptions, permits required for authorized care of dependents residing with a sponsor must be attached to the original copies of DA Form 1863 on claims submitted by attending physicians and hospitals. Claims submitted by others, such as an assistant surgeon, radiologist, pathologist, anesthesiologist, dentist (when not in the capacity of the attending physician), consultant, psychiatrist, private duty nurse, anesthetist and physical therapist, will be authorized for payment without a permit. The claim form, however, must show that a permit was furnished to the attending physician and/or to the hospital.

SPOUSES AND CHILDREN RESIDING APART FROM SPONSORS. — Eligible dependents living apart from their sponsors will continue to have freedom of choice of military medical facilities or civilian medical sources, as formerly. The curtailment of types of services, effective the first of this month, applies to all dependents, however, including this group.

CARE NO LONGER PAYABLE. — To comply with the budgetary limitations fixed by the Congress for the fiscal year 1959, the Department of Defense has announced its decision to make the following care and services, commenced on or after Oct. 1, 1958, NOT payable by the government under the Medicare program:

1. The treatment of fractures, dislocations, lacerations and other wounds on an outpatient basis.

2. The termination visit, which refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient.

3. Outpatient presurgical and postsurgical tests and procedures, formerly authorized in an amount of $75 before hospitalization and $50 after hospitalization.

4. Neonatal visits, the two well baby visits formerly authorized after the mother and child leave the hospital.

5. The treatment of acute emotional disorders, except for the care of such a disorder during the period of hospitalization of a spouse or child for a condition that qualifies as authorized care.

6. Elective surgery. The elective surgical procedures not now authorized are those which, from a practical viewpoint, permit the patient and the physician to plan for them. They are described as "medical or surgical care that is desired or requested by the patient which in the opinion of the cognizant medical authority can be planned, subsequently scheduled, and effectively treated at a later date without detriment to the patient, e.g., diagnostic surveys, cosmetic surgery, reconstructive surgery, tonsillectomies, uncomplicated hernias, and interval appendectomies."

It is apparent, therefore, that a great many surgical procedures payable in the past are not now authorized unless, because of unusual circumstances, they would qualify under bona fide surgical emergencies requiring hospitalization. Examples mentioned are tonsillectomy, dilation and curettage, hysterectomy (routine), ligation of fallopian tubes, heart surgery, submucous resection, rhinoplasty and reconstructive orthopedic and plastic procedures.

Surgical Procedures Authorized for Payment. — Surgical emergencies requiring hospitalization, acute surgical conditions, and injuries requiring hospitalization will continue to be payable. In bona fide surgical emergencies the patients will necessarily be acutely ill and in need of immediate hospitalization and treatment. Examples include perforated duodenal ulcer, hemorrhage with shock, bowel obstruction, and similar recognized emergencies.

Acute surgical conditions, while not considered emergencies, require prompt treatment of an acutely ill patient in a hospital when time does not permit the patient to anticipate or plan for the care required. The spirit of this requirement is that the ill patient is in clinical need of hospitalization without delay with a view to surgical correction of the basic condition. Acute appendicitis, empyema of the gallbladder, twisted ovarian cyst, strangulated hernia, pelvic abscess, and renal or ureteral calculi with colic are examples. Suspected or proved malignant disease, for which the patient requires hospitalization, is payable only if the case qualifies as a surgical emergency or an acute surgical condition as here defined.

Injuries of such clinical severity as to require hospitalization continue to be payable, but hospitalization is authorized for treatment of the acute phase only. Readmission for treatment of chronic stages or sequelae of injury is not payable unless an acute medical or an acute surgical requirement is shown, such as osteomyelitis with acute exacerbation.

Medical Provisions. — The provisions pertaining to the treatment of acute medical conditions remain unchanged. The admission of patients not acutely ill for diagnostic surveys will, however, not be payable.

Dental Provisions. — Provisions relating to dental care likewise remain unchanged. Adjunctive dental care, however, is now payable only when it is an integral and necessary part of the authorized surgical and medical conditions herein described. It must be clearly shown that the dental care furnished was required for the proper treatment of the basic medical or surgical condition for which the patient was hospitalized.

Physicians and hospitals are urged to give particular attention to this information in this difficult readjustment period. Since hospital claims will now require careful completion to meet legal requirements, physicians are urged to assist hospitals in every way possible in this regard by providing a specific diagnosis and, when indicated, a clinical statement which will assure payment under the program. The military services have instituted an extensive program to apprise military personnel and their dependents of the changes in Medicare. They also, of course, have the responsibility of issuing permits to eligible dependents residing with their sponsors when uniformed services medical facilities are inadequate or not available.

Continued Nuclear Experimentation Essential for Peaceful Purposes

Medical and industrial progress necessitates continued nuclear experimentation as a means of furthering progress in making nuclear energy useful to mankind, Dr. Louis M. Orr, of Orlando, told the 500 delegates attending the Twelfth General Assembly of the World Medical Association at Copenhagen in mid-August. Dr. Orr, consultant at the Institute of Nuclear Studies at Oak Ridge, Tenn., and President-Elect of the American Medical Association, addressed the assembly on "The Biological Effects of Nuclear Radiation."

In reply to the standard arguments of opponents of nuclear testing that radioactive fall-out is injurious to the world's present population and a peril to future generations, Dr. Orr said he would agree if full scale thermonuclear tests were continuing as an annual procedure in which tons and tons of radioactive material are thrown into the sky at an indiscriminate rate. He explained, however, that, in the United States at least, at the present time the emphasis is on smaller tests and on "clean" weapons that produce as little radioactivity as possible. Citing as an example the recent test in the United States in which a weapon fired underground was completely contained, he said that the escape of essentially no radioactive fall-out makes possible new peaceful applications with "contained" explosions. Thus,

in due time, the new tests will yield knowledge most beneficial to all peoples, especially in such fields as medicine, mining, chemistry, power generation and agriculture.

Discounting the fears expressed by many on the danger of fall-out, Dr. Orr was of the opinion that the public faces greater dangers of radiation from the improper, frequent or prolonged use of roentgen rays than from the fall-out incident to nuclear experiments. Air and soil contamination from current nuclear tests is reduced below the danger point to both man and animals, he declared and added: "It is a fact that for centuries mankind has lived with an amount of natural radiation some 30 times greater than the fall-out to this date from nuclear tests. . . . If nuclear testings all over the world are continued at their present level, or at the same rate as that of the last few years since the beginning of testing, the 30 year fall-out dose would be . . . negligible as far as biological effects from fall-outs can be determined to date."

Dr. Orr told the world group that excessive doses of radioactive strontium-90 could cause cancer and leukemia and therefore it could be concluded that harmful results could occur from fall-out from nuclear tests, but he added that strontium-90 has been used "to frighten rather than to enlighten people." The present level of strontium in the bones of American children, he said, is less than one per cent of the maximum danger point for the population. His conclusion was: "No freedom-loving scientist would advocate the indiscriminate testing of atomic devices, especially of thermonuclear weapons, but neither would he promote a discontinuation of regulated, reasonable testing that can benefit all mankind in the course of time even though there may be some small unknown quantity of risk involved."

At the opening session of the Copenhagen meeting, the physicians of the world initiated a campaign to keep the medical profession in every country fully informed on the effects of nuclear radiation. For several years this world organization has considered various resolutions on nuclear experimentation, and some of the national medical associations comprising the membership have urged that their organizations be provided with factual information on the subject. Dr. Orr, an authority in this field, was selected to inform the membership of the scientific developments in the field, devoid of the political and emotional factors that have become associated with the topic.

Southern Medical Association New Home Formally Dedicated

The formal opening last month of the $250,000 home of the Southern Medical Association was an occasion for rejoicing among the more than 12,000 members of this outstanding medical organization of the South. On Sunday, September 7, open house was held throughout the afternoon, and at 4 p.m. dedication ceremonies were conducted. Among the several thousand invited guests were distinguished representatives of the medical profession, local, state and national officials, and lay and Auxiliary leaders.

In charge of the ceremonies was V. O. Foster, Executive Secretary, and participating in the program were the three past presidents most active in the promotion, construction and occupancy of the building since it was first proposed in 1955, Drs. R. L. Sanders, of Memphis, W. Raymond McKenzie, of Baltimore, and J. P. Culpepper Jr., of Hattiesburg, and the president now serving, Dr. W. Kelly West, of Oklahoma City. Also taking part in the dedication were Dr. Lee F. Turlington, of Birmingham, who served as chairman of the building committee, and Mrs. Walker L. Curtis, of College Park, Ga., the president of the Woman's Auxiliary to the association.

Appropriately described by Dr. West as "a magnificent monument to Southern medicine," the handsome split-level structure now provides the first permanent home for this organization which has maintained offices in Birmingham for 43 years of its 52 year history. The first level includes an imposing lobby, storage rooms and an office for the Woman's Auxiliary. On the second level are another lobby, a conference-library room, executive offices, editorial offices of the Southern Medical Journal, mailing room, employee lunch room and additional office work space. Ample parking area is provided. Representing more than one year of construction as well as several years of planning, this new headquarters office building is one of the country's most modern association buildings.

The consummation of this building project reflects the steady growth of the Southern Medical Association, which draws its members from 16 Southern states and the District of Columbia. In the last four years alone it has increased its membership by approximately 4,000. When this regional organization was founded in Chattanooga in 1906 for the exclusive purpose of developing and fostering scientific medicine, only six states



The first permanent home of the Southern Medical Association, located at 2601 Highland Avenue, Birmingham, Alabama.

participated. Florida was one of them, along with Alabama, Georgia, Louisiana, Mississippi and Tennessee. Today Florida Medicine salutes this great medical society of the South and takes pride in its growth and accomplishments through the years. The Florida Medical Association and The Journal of the Florida Medical Association congratulate the Southern Medical Association and the Southern Medical Journal on their latest achievement—the acquisition of a well deserved permanent home.

American Medical Association Journal Celebrates 75th Anniversary

Unique in the annals of American medical journalism is the 75th Anniversary issue of The Journal of the American Medical Association. With a special cover design, this issue appeared as volume 167, number 11, July 12, 1958. It is indeed a noteworthy example of medical journalism at its best and a distinguished contribution to the march of medicine through the recorded word.

"Partners in Progress" was the happy choice of a theme for this anniversary celebration. Developing this theme editorially, Dr. Austin Smith, Editor, commented:

"The Journal of the American Medical Association is now 75 years old, although in this modern age there is the temptation to use the words 75 years young. It is not four score years old, and yet more significant events have occurred during this time than, perhaps, in hundreds of preceding years. It makes no difference whether one thinks of engineering, medicine, law enforcement, or any other field; the changes that have occurred are so dramatic, so challenging, it is difficult to think of any corner of the earth, any phase of life, that is not being affected. And this is only the beginning. What is on the horizon seems even more fantastic to contemplate.

"Most of us accept our modern miracles with little more than passing wonderment or sometimes momentary thankfulness. Often we do not understand; usually we do not appreciate. In fact, too often our eyes and our thoughts remain confined to our own fields of interest without realizing how much each field contributes to another, how much each is dependent on another, or how many people and how much training and experience are involved in the various areas of effort.

"Elsewhere in this issue of The Journal are articles from acknowledged leaders in their fields. They are known internationally, and yet they can think in terms of the individual as well as of a nation or of the world. As one reads their writings, there grows a recognition and an appreciation of a fundamental fact: they are all partners in progress."

Twenty-one leaders of state, of industry, of business, of research, of writers, of publishers and of other groups comprise the list of contributing authors. Among them are such notables as President Dwight D. Eisenhower, Dr. Gunnar Gundersen, John Daly, Walt Disney, Harlan H. Hatcher, J. Edgar Hoover, Charles F. Kettering, Edward V. Rickenbacker, Charles S. Rhyne, John Steinbeck and DeWitt Wallace, to name but a few. The opinions expressed by these partners in the progress of medical science in the broadest sense make stimulating and refreshing reading.

Continuing editorially, Dr. Smith reminded the practicing physician of his important partnership role, for he is part of community life and his work influences as widely that of others as they in turn influence his work. No one can exist without the direct or indirect contributions of others, he pointed out, and leadership is necessary, but understanding is likewise as important, and none are better equipped to promote it by example and precept than acknowledged leaders

in their fields, such as the guest contributors to this notable issue, and the physician.

"Writer, news commentator, industrialist, educator, name whom you will," observed Dr. Smith in conclusion, "are all partners in living in our country. This in itself engenders a depth of responsibility that is sobering, but when one remembers that much of the world today is looking for leadership, all of us must be mindful of additional responsibility as we work and play. Perhaps the people in some of the countries elsewhere might have had fewer problems if they had paused long enough in their work and play to encourage men and women to shake hands with each other as partners in orderly progress. Maybe there would be less fist shaking today."

The Florida Medical Association and The Journal of the Florida Medical Association extend heartiest congratulations to Dr. Smith and his staff and to the American Medical Association on this 75th Anniversary number and on the timely choice of the theme, "Partners in Progress."

Southern Medical Association Holds Annual Meeting in New Orleans November 3-6, 1958

The Fifty-Second Annual Meeting of the Southern Medical Association will convene in New Orleans on November 3 and continue through November 6. The scientific meetings will be held in the Auditorium, where the exhibits also will be located.

President W. Kelly West of Oklahoma City will have as his special guest Dr. F. J. L. Blasingame, General Manager of the American Medical Association, who is a loyal Southern Medical Association member. Dr. Blasingame will deliver an address at the President's luncheon on Monday, November 3.

An excellent scientific program has been arranged for the 20 sections representing the major medical and surgical specialties. Each section has scheduled a lecture by a distinguished guest speaker in addition to the presentations of the members. More than 300 papers will be presented, and there will be a Geriatrics Symposium.

Other features include selected scientific exhibits, selected technical exhibits, four color television programs, section luncheons and dinners, some 30 alumni reunions, fraternity reunions, the thirty-fifth Southern Medical Association golf tournament, the past presidents' dinner, the past councilors' breakfast, the President's luncheon, President's night—the annual dinner dance, the Woman's Auxiliary official tours, and the Doctors' Day luncheon sponsored by the Auxiliary.

The medical student representatives program, begun two years ago at the Washington semicentennial meeting, will be continued. This project consists of inviting an elected representative of the senior class of medical schools in the South to attend the meeting. The association will have as official guests this year seniors from 13 schools.

Adding further to the variety and appeal of the scientific assembly will be the sessions of four societies meeting conjointly. These societies are the American College of Chest Physicians, Southern Chapter; The Association for Research in Ophthalmology, Inc., Southern Section; the Southern Gynecological and Obstetrical Society; and the Flying Physicians Association, Inc.

Florida physicians serving as officers of the Southern Medical Association during 1957-1958 are Dr. Donald F. Marion, of Miami, Second Vice President; Dr. Joseph S. Stewart, of Miami, Councilor; Dr. Walter C. Jones, of Miami, member of the Board of Trustees and a past president; and Dr. Sullivan G. Bedell, of Jacksonville, member of the Editorial Board. Section officers are Dr. John T. Stage, of Jacksonville, Vice Chairman of the Section on Anesthesiology; Dr. Hugh B. Goodwin Jr., of Fort Pierce, Vice Chairman of the Section on General Practice; Dr. Arthur H. Weiland, of Coral Gables, Vice Chairman of the Section on Orthopedic and Traumatic Surgery; Dr. W. A. D. Anderson, of Miami, Chairman of the Section on Pathology; Dr. Albert G. Lewis Jr., of Tampa, Secretary of the Section on Public Health; Dr. J. Maxey Dell Jr., of Gainesville, Vice Chairman of the Section on Radiology; Dr. John J. Farrell, of Miami, Vice Chairman of the Section on Surgery; and Dr. Jack A. McKenzie, of Miami, Vice Chairman of the Section on Urology.

Florida Medical Association Eighty-Fifth Annual Meeting

The date of the 1959 Annual Meeting of the Florida Medical Association has been announced as May 2-6. It is scheduled for the Americana Hotel in Bal Harbour, a section of Miami Beach.

Florida Academy of General Practice
Ninth Annual Scientific Assembly
West Palm Beach, Oct. 30 - Nov. 1

Late this month the Florida Academy of General Practice will hold its Ninth Annual Scientific Assembly at the Hotel George Washington in West Palm Beach. Registration will begin on Thursday afternoon, October 30, and on Thursday night all members of the Academy are invited to attend a meeting of the Board of Directors and Chairmen of all Standing Committees.

The scientific program will be presented at morning and afternoon sessions on Friday, October 31 and Saturday, November 1. Featured on the program are four symposiums dealing with psychiatry in general practice, anticoagulant therapy, disaster planning and increasing the cancer cure rate.

Dr. Charles R. Sias, President, will preside over the business session on Friday night. The meeting will close with the annual banquet on Saturday night.

PROGRAM
NINTH ANNUAL SCIENTIFIC ASSEMBLY
FLORIDA ACADEMY OF GENERAL PRACTICE
OCTOBER 30 - NOVEMBER 1, 1958
HOTEL GEORGE WASHINGTON, WEST PALM BEACH

THURSDAY, OCTOBER 30

1:00 p.m. Registration

8:00 p.m. Meeting of the Board of Directors and Chairmen of all Standing Committees. All members of the Academy are invited to attend

FRIDAY, OCTOBER 31

8:00 a.m. Registration

8:30 a.m. Visit technical exhibits

9:00 a.m. Invocation and welcome to the Assembly

Symposium on Psychiatry in General Practice

Dr. Arnold H. Eichert, presiding

9:30 a.m. "Screening and Placement of Patients with Psychiatric Disorders," Dr. Richard W. Anderson

10:15 a.m. "Management of Psychiatric Disorders in a General Practice," Dr. Zack Russ Jr.

11:00 a.m. Visit Technical Exhibits

11:15 a.m. "A Detailed Look at the Follow-up Program of Patients on Trial Visit From the State Hospital," Melvin P. Reid, Ph.D.

12:00 Round table discussion and question period
Drs. Reid, Anderson and Russ

12:45 p.m. Luncheon

1:30 p.m. Visit Technical Exhibits

Symposium on Anticoagulant Therapy

Dr. Richard A. Mills, presiding

2:00 p.m. "The Present Status of Anticoagulant Treatment of Cerebral Vascular Lesions," Dr. William T. Foley

2:45 p.m. "Value of Long Term Anticoagulants in Coronary Atherosclerosis," Dr. E. Sterling Nichol

3:30 p.m. Visit Technical Exhibits

3:45 p.m. "Experimental Cerebral Infarction and Anticoagulant Therapy," Dr. Jack P. Whisnant

4:30 p.m. Round table discussion and question period
Drs. Foley, Nichol and Whisnant

5:15 p.m. Visit Technical Exhibits

8:00 p.m. Business Session
Dr. Charles R. Sias, President, presiding

SATURDAY, NOVEMBER 1

8:00 a.m. Registration

8:30 a.m. Visit Technical Exhibits

Symposium on Disaster Planning

Dr. Franklin J. Evans, presiding

9:30 a.m. "Over-all Disaster Planning," Dr. J. Rocher Chappell

10:15 a.m. "Radiation Effects and Their Management," Col. Clinton S. Maupin, MC, USA

11:00 a.m. Visit Technical Exhibits

11:15 a.m. "Thermal and Blast Injuries," Col. Joseph R. Shaeffer, MC, USA
12:00 Round table discussion and question period Dr. Chappell, Colonel Maupin and Colonel Shaeffer
12:45 p.m. Luncheon
1:30 p.m. Visit Technical Exhibits

Symposium on Increasing the Cancer Cure Rate

Dr. Paul J. Coughlin, presiding
2:00 p.m. "Clinical Application of the Vaginal Smear Test," Dr. Emerson Day
2:40 p.m. Intermission
2:45 p.m. "New Concepts in Management of Cancer of the Head and Neck," Dr. Harry W. Southwick
3:25 p.m. Intermission
3:30 p.m. "Cancer of the Colon and Rectum—Significance of the Polyp," Dr. Michael R. Deddish
4:10 p.m. Intermission
4:15 p.m. Round table discussion and question period
Drs. Day, Deddish and Southwick
5:00 p.m. Visit Technical Exhibits
6:30 p.m. Cocktail Party
7:15 p.m. Annual Banquet. Entertainment and Dancing. No addresses. Dress optional.

Association Desires Pictures Of Past Presidents

The photographs of the past presidents of the Florida Medical Association are being placed on display in the Association's permanent headquarters as a tribute to these outstanding physicians who served in their own important way toward building the Association into the dynamic organization it is today.

The gallery is not complete. So far it has not been possible to obtain photographs of all the past presidents.

Efforts to collect the pictures began before the headquarters building was occupied. It was not difficult to obtain photographs of the presidents who had served in the past 40 years. Relatives of deceased presidents were most cooperative.

For the years 1874 to 1918, the task became more difficult. All known relatives of the presidents who served during this period have been contacted, and some photographs were obtained. Published historical material has been searched for photographs that may be copied; however, only a few were found.

It is hoped that the readers of The Journal will assist in furnishing what information they may have toward locating the photographs missing from the gallery. Needed are pictures of Dr. Francis P. Wellford, Jacksonville, 1877; Dr. R. D. Murray, Key West, 1878; Dr. Charles J. Kenworthy, Jacksonville, 1880; Dr. George W. Betton, Tallahassee, 1881; Dr. R. B. S. Hargis, Pensacola, 1882; Dr. John P. Wall, Tampa, 1884; Dr. J. W. Hicks, Orlando, 1887; Dr. Frank H. Caldwell, Sanford, 1893; Dr. T. D. Rush, Apalachicola, 1894; Dr. C. B. Sweeting, Key West, 1895; Dr. H. K. DuBois, Port Orange, 1896; Dr. R. P. Izlar, Ocala, 1898; Dr. J. Harrison Hodges, Gainesville, 1899; Dr. W. H. Hughlett, Cocoa, 1900; Dr. A. J. Wakefield, Jacksonville, 1901; Dr. J. Harris Pierpont, Pensacola, 1902; Dr. E. N. Liell, Jacksonville, 1904; Dr. John MacDiarmid, Deland, 1906; Dr. J. F. McKinistry, Gainesville, 1908; Dr. F. C. Moor, Tallahassee, 1914; and Dr. F. J. Walter, San Diego, Calif., 1918.

Old photographs in reasonably good condition can be copied. Pictures in books or manuscripts can also be used. This material will be carefully handled and returned as soon as possible.

Florida Diabetes Association Miami Beach, October 30-31

The Florida Diabetes Association will hold its sixth annual session at the Balmoral Hotel, Bal Harbour, Miami Beach, on October 30 and 31, 1958. Registration will begin at 9 a.m. on Thursday, October 30, and the registration fee of $25 carries the privilege of membership in the association for one year.

A luncheon meeting of the Board of Governors is planned for Thursday, October 30. On Thursday night at 8 p.m. a public meeting will be sponsored by the Greater Miami Lay Diabetes Association. The annual meeting of the association will be held at 1:30 p.m. on Friday, at which time there will be an election of officers. Many registrants may wish to attend the Vanderbilt-Miami football game, which is scheduled for the Orange Bowl at 8:15 on Friday night, October 31.

The scientific program is presented in cooperation with the Florida Medical Association, the

Florida State Board of Health and the Division of Postgraduate Education of the College of Medicine of the University of Florida. The opening lecture will be presented at 10 a.m. on Thursday, and the concluding lecture at 3:15 p.m. on Friday. The program is approved for postgraduate study, Category I, by the American Academy of General Practice.

The guest speakers will be Dr. James B. Field, S. A. Surgeon, U. S. Public Health Service, National Institutes of Health, Bethesda, Md.; Dr. Thomas F. Frawley, Director, Department of Endocrinology and Metabolism, The Albany Medical College of Union University, Albany, N. Y.; and Dr. Howard F. Root, Physician-in-Chief, Deaconess Hospital, and Associate Professor of Medicine, Harvard Medical School, Boston. Member speakers will be Dr. A. Gorman Hills, Associate Professor of Medicine, University of Miami School of Medicine, Miami; Dr. Joseph J. Lowenthal, Jacksonville; and Dr. William C. Thomas Jr., Assistant Professor of Medicine, College of Medicine, University of Florida, Gainesville.

Officers of the association are Dr. George H. Garmany, President, Tallahassee; Dr. Joseph J. Lowenthal, President-Elect, Jacksonville; and Dr. Grover C. Collins, Secretary-Treasurer, Palatka.

PROGRAM
SIXTH ANNUAL MEETING
FLORIDA DIABETES ASSOCIATION
BALMORAL HOTEL, MIAMI BEACH, OCTOBER 30-31

THURSDAY, OCTOBER 30

Moderator: Dr. George H. Garmany

9:00	Registration	
10:00	"Insulin Resistance in Diabetic Acidosis"	Dr. Field
10:30	"Chronic Insulin Resistance"	Dr. Field
11:00	Recess	
11:15	"Diabetic Acidosis"	Dr. Root
11:45	Question and Answer period	
12:30	Luncheon Meeting—Board of Governors—Balmoral Hotel	

Moderator: Dr. Richard H. Sinden

2:00	"Some Observations Concerning the Natural History of Diabetes Mellitus"	Dr. Hills
2:30	"Hyperglycemic States Not Primarily Due to Lack of Insulin"	Dr. Frawley
3:00	Recess	
3:15	"Control of Diabetes and Its Vascular Sequelae"	Dr. Root
3:45	Question and Answer period	
8:00	Public Meeting	

FRIDAY, OCTOBER 31

Moderator: Dr. George F. Schmitt Jr.

10:00	"Experiences with Chlorpropamide, A New Anti-Diabetic Agent"	Dr. Lowenthal
10:30	"Mode of Action of Sulfonylureas: A Resolving Enigma"	Dr. Frawley
11:00	Recess	
11:15	"The Eyes and Diabetes"	Dr. Root
11:30	Question and Answer period	

Moderator: Dr. Joseph J. Lowenthal

1:30	Business Meeting	
2:00	"Vitamin Metabolism in Diabetes Mellitus"	Dr. Field
2:30	"Gynecomastia"	Dr. Thomas
3:00	Recess	
3:15	"New Clinical and Pathophysiological Knowledge of the Adrenogential Syndrome and Its Variants"	Dr. Frawley
3:45	Question and Answer period	

Ninth Biennial Meeting
Southeastern States Cancer Seminar
Tampa, November 19-21, 1958

The biennial meeting of the Southeastern States Cancer Seminar is scheduled for November 19, 20 and 21 and will be held at the Hillsboro Hotel in Tampa. It will be presented by the Hillsborough County Medical Association, supported by the American Cancer Society, Florida Division, and the Florida State Board of Health in cooperation with the Florida Medical Association.

The course is approved for formal education credit by the American Academy of General Practice. There is no registration fee, and all physicians are cordially invited to attend.

The 11 lecturers, listed in the September issue of The Journal, are outstanding in the cancer field. These distinguished guest speakers and the timely subjects they will discuss should attract a large attendance from the entire Southeast.

The local committee in charge of arrangements is the Cancer Committee of the Hillsborough County Medical Association. Dr. Joseph D. Brown and Dr. Charles Catanzaro are co-chairmen of this committee.

PROGRAM
NINTH BIENNIAL MEETING
SOUTHEASTERN STATES CANCER SEMINAR
HILLSBORO HOTEL, TAMPA
NOVEMBER 19-21, 1958

WEDNESDAY, NOVEMBER 19

11:00 a.m. Registration — Lobby, Hillsboro Hotel

Dr. Joseph D. Brown, Co-chairman Cancer Committee, presiding

1:50 p.m. Opening remarks — Dr. Joseph D. Brown

2:00 p.m. "Premalignant Lesions of the Skin." Dr. James L. Pipkin

2:30 p.m. "The Treatment of Oral Cancer," Dr. Stanley L. Lane

3:00 p.m. "The Management of Malignancies of the Skin," Dr. James L. Pipkin

3:30 p.m. Intermission

3:45 p.m. "Oral Cancer and Radiation Therapy," Drs. Simon Kramer and Joseph P. Concannon

4:15 p.m. Panel discussion

Dr. Wesley W. Wilson, moderator

Drs. James L. Pipkin, Stanley L. Lane, Simon Kramer and A. Reynolds Crane

THURSDAY, NOVEMBER 20

Dr. Harold G. Nix, presiding

9:00 a.m. "Recent Advances in Radiation Therapy of Pelvic Malignancies," Dr. Herbert E. Schmitz

9:30 a.m. "Recent Advances in Surgical Therapy of Pelvic Malignancies," Dr. Joseph V. Meigs

10:00 a.m. Panel discussion—"Radiation Therapy Versus Surgical Therapy of Pelvic Malignancies"

Dr. Harold G. Nix, moderator

Drs. Herbert E. Schmitz, Joseph V. Meigs and Joseph P. Concannon

10:30 a.m. Intermission

10:45 a.m. "In-Situ Carcinoma of the Uterus," Dr. Joseph V. Meigs

11:30 a.m. Panel Discussion — "Menopausal and Postmenopausal Bleeding"

Dr. Harold G. Nix, moderator

Drs. Herbert E. Schmitz, Joseph V. Meigs, A. Reynolds Crane and Joseph P. Concannon

12:00 Luncheon

Dr. C. Frank Chunn, presiding

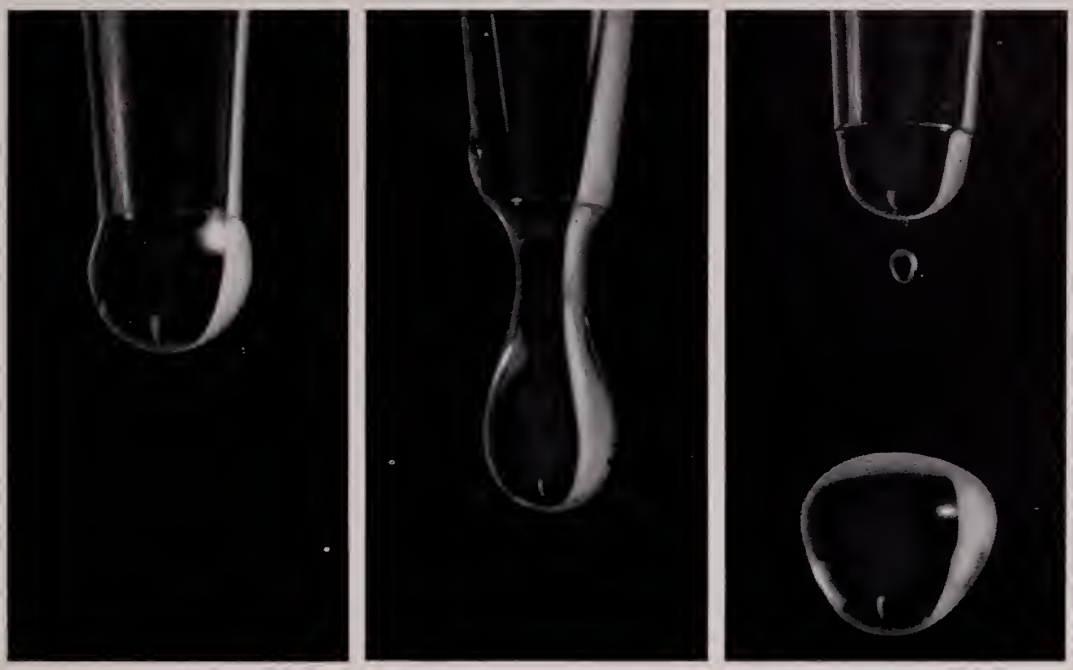
2:00 p.m. "Surgical Aspects of Carcinoma of the Thyroid," Dr. Kenneth W. Warren

2:30 p.m. "Radiation Therapy for Carcinoma of the Thyroid," Drs. Joseph P. Concannon and Simon Kramer

3:00 p.m. Panel discussion

Dr. C. Frank Chunn, moderator

Drs. Kenneth W. Warren, Joseph P. Concannon and A. Reynolds Crane



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3:30 p.m. Intermission

3:45 p.m. "Carcinoma of the Colon," Dr. James Rives

4:15 p.m. Panel discussion
Dr. C. Frank Chunn, moderator
Drs. James Rives and A. Reynolds Crane

FRIDAY, NOVEMBER 21
Dr. Charles Catanzaro, presiding

9:00 a.m. "The Treatment of Leukemias," Dr. Max M. Strumia

9:30 a.m. "Radiation Therapy of Leukemias and Related Diseases." Drs. Simon Kramer and Joseph P. Concannon

10:00 a.m. Intermission

10:10 a.m. "Splenectomy in Leukemias and Related Diseases," Dr. Max M. Strumia

10:40 a.m. Panel discussion
Dr. Charles Catanzaro, moderator
Drs. Max M. Strumia and Simon Kramer

11:10 a.m. "Trauma and the Law—The Physician and Cancer," Dr. A. Reynolds Crane

12:00 Luncheon

Dr. Linus W. Hewit, presiding

2:00 p.m. "Various Aspects of Prostatic Cancer." Dr. Ruben H. Flocks

2:30 p.m. "Hypernephroma," Dr. Ruben H. Flocks

3:00 p.m. Intermission

3:15 p.m. "Palliative Radiation Therapy in Genitourinary Cancer." Drs. Joseph P. Concannon and Simon Kramer

4:15 p.m. Panel discussion — "Prostatic Cancer Hypernephroma"
Dr. Linus W. Hewit, moderator
Drs. Ruben H. Flocks, Joseph P. Concannon and A. Reynolds Crane.

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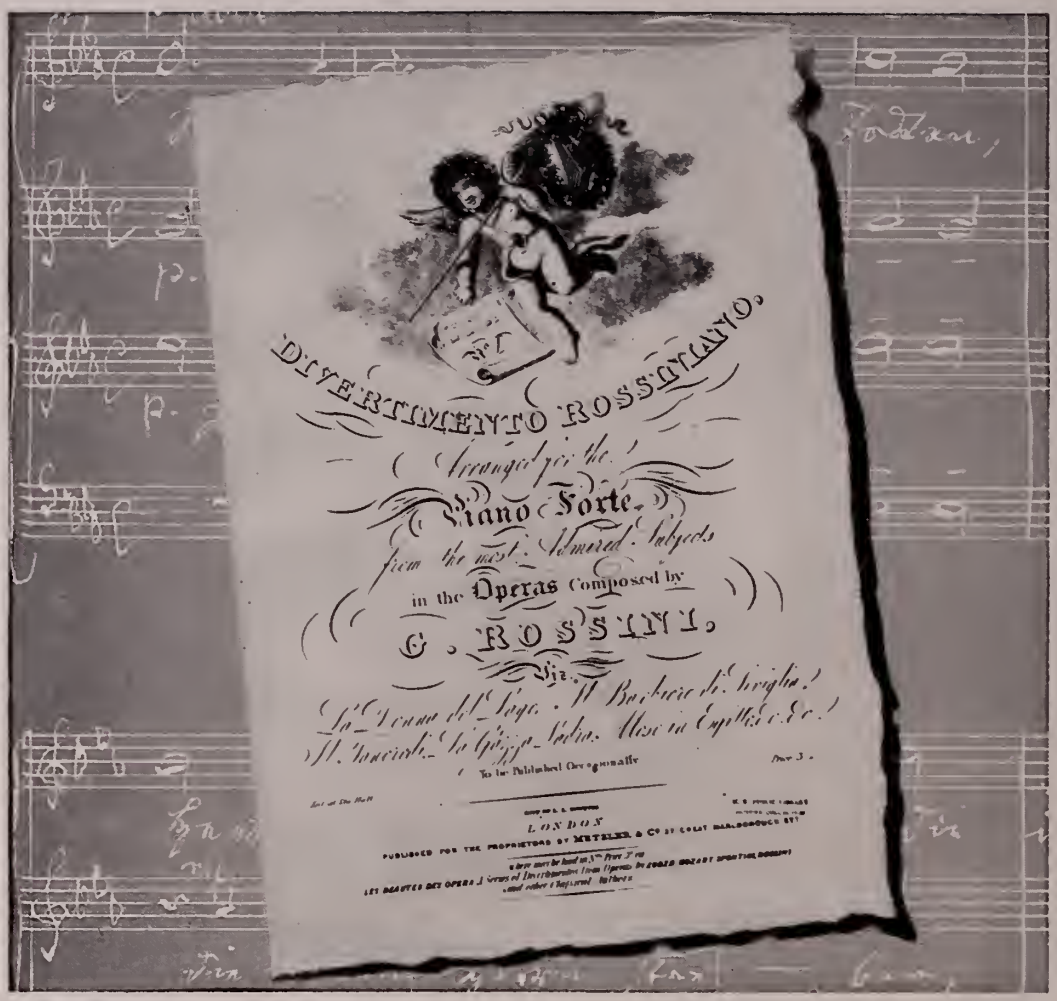
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1. Swartzwelder, J. C., et al.: J. A. M. A., 165:2063, 1957.

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OTHERS ARE SAYING

Prepare Early For Age

Although recreation is important at all ages, it is imperative for one after retirement. Hobbies, sports, games and travel are the most common forms, except probably dancing in this county. One should not limit his interest to one.

It is difficult to adjust from an active life to a life where alarm clocks have no place, unless the person has learned to play during his business career. Annuities alone, do not guarantee happiness.

Recreation cannot be prescribed. A form that appeals to one, might be boredom to another. For example, golf must be a wonderful game for there are so many enthusiasts of all ages playing it and more power to them. To others, it reminds them of a kitten batting a spool and then jumping after it. Some optimists will sit contentedly by the hour, with a rod and line and be almost annoyed if a fish commits suicide because he visualizes cleaning it, since the neighbors have plenty of fish by the same method.

Hobbies of greatest interest are in production so that friends may at least profess to admire the product.

Woodwork is excellent, but if power tools are used, great care must be employed to keep all digits attached. Little damage can be done with hand tools or even a power jigsaw and beautiful work can be produced by them.

Ceramics are fascinating and safe. Likewise oil and water color painting. The artist's dream can be molded into the vase or expressed on canvas.

Photography is the simplest hobby and doesn't require much skill or equipment to start. The owner of a Brownie or a Leika can have equal fun. The Poloroid is a comparatively new development and with it, one can have a finished picture in a minute. He misses the dark room adventure of developing, printing and enlarging black and white pictures to which oil or water paints can be added with artistic results. Color slides and motion pictures must be finished professionally for equipment is too expensive for an amateur. With either, one can entertain himself at least, by showing them to friends. It is well to be selective to keep company coming. Travel pictures have more appeal to them than those of family groups, for obvious reasons.

WCM, Picomeso Mail Bag, April 1958



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through vomiting or diarrhea—

Valentine's MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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STATE NEWS ITEMS

A special showing of the University of Florida's new Teaching Hospital and Clinics has been scheduled for physicians on Wednesday afternoon, October 15. The showing will begin with a brief orientation program in the Medical Sciences Building at 2 p.m. on that date. The clinical staff of the Hospital and Clinics will be on hand to consult with visiting physicians concerning the physical plant and equipment available in the new $10 million structure.

Dr. Sherman B. Forbes of Tampa attended a Postgraduate Conference in Strabismus on August 27-30 in San Francisco presented by the Division of Ophthalmology of Stanford University School of Medicine.

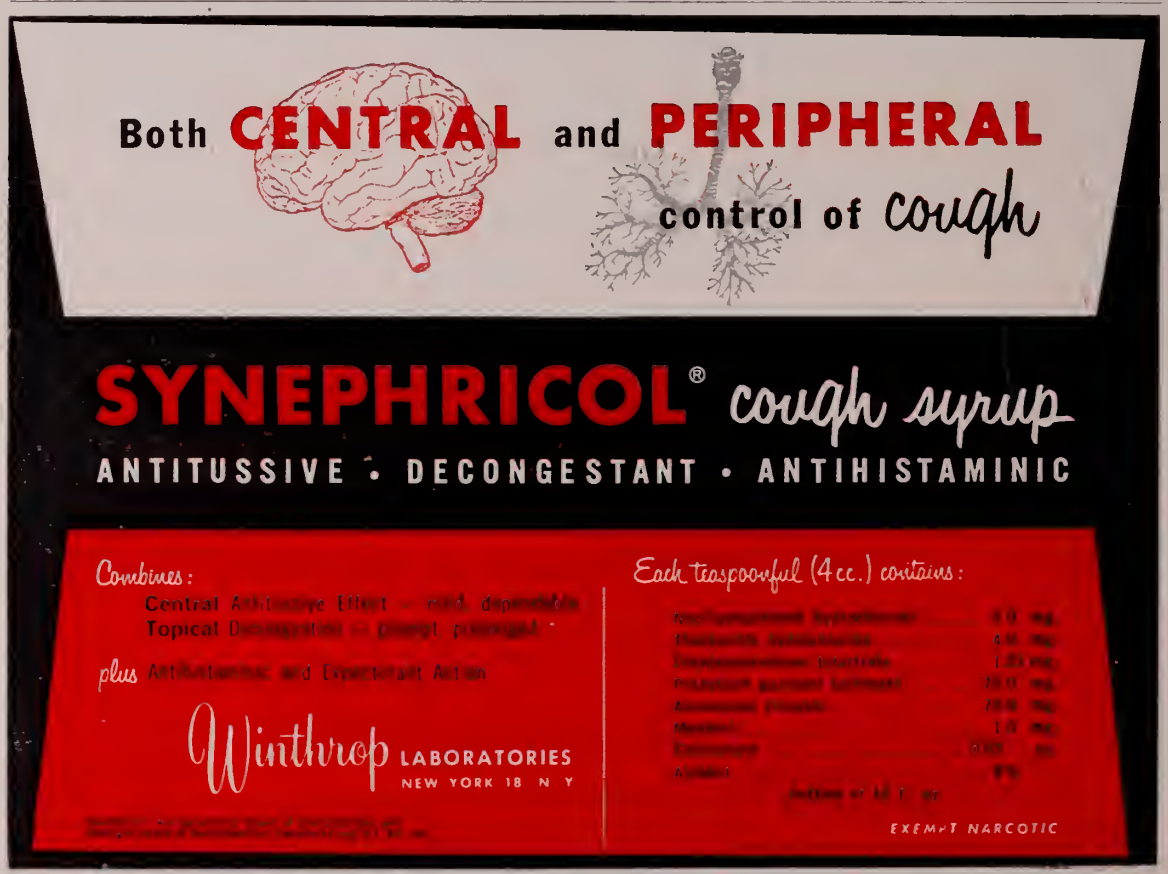
Dr. DeWitt C. Daughtry of Miami, secretary-treasurer of the Southern Chapter, American College of Chest Physicians, reports that an excellent program has been arranged for the annual meeting of the College of Chest Physicians being held November 2-3 in the Jung Hotel, New Orleans, immediately prior to the meeting of the Southern Medical Association. Dr. John Seabury of New Orleans is general chairman of the scientific session, with Dr. A. H. Russakoff of Birmingham and Dr. Robert R. Shaw of Dallas as chairmen of the Medical and Surgical sections respectively.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, has returned from an extensive trip through the northwest portion of the United States where he visited various clinics.

The Southeastern Allergy Association is holding its annual meeting October 31-November 1 at the Heart of Atlanta Motel in Atlanta, Ga., according to announcement by Dr. Katharine B. MacInnis of Columbia, S. C., secretary-treasurer. Dr. George F. Hieber of St. Petersburg will be installed as president at the session.

The postgraduate course "Introduction to Clinical Electrocardiography" began September 29 at Mount Sinai Hospital, Miami Beach, and will be concluded December 19. Sessions are held

(Continued on page 454)



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starts
to

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in delicious chocolate-like nuggets



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or take–
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tops with adults, too.

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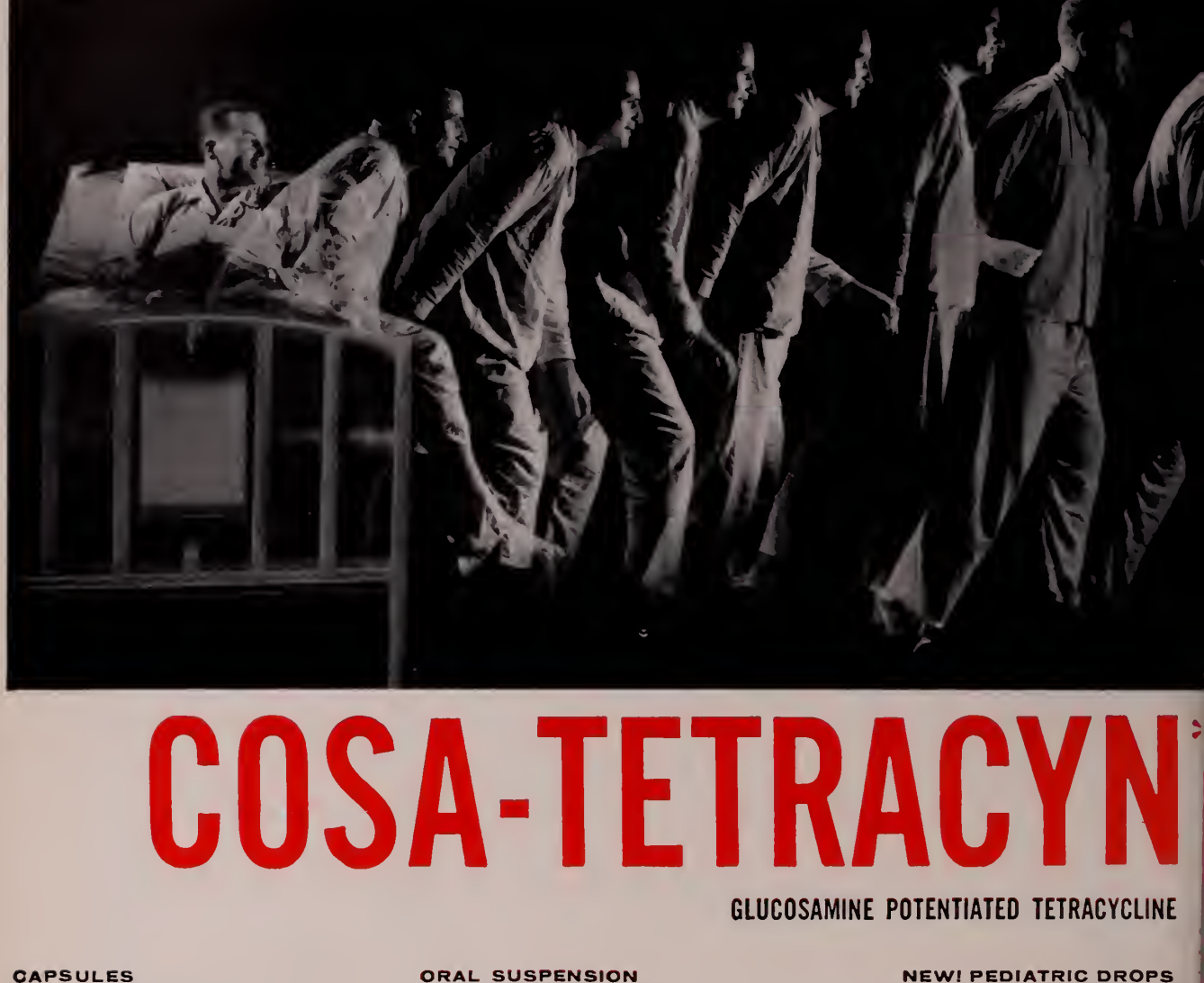
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Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

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REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. M & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84 1 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Me & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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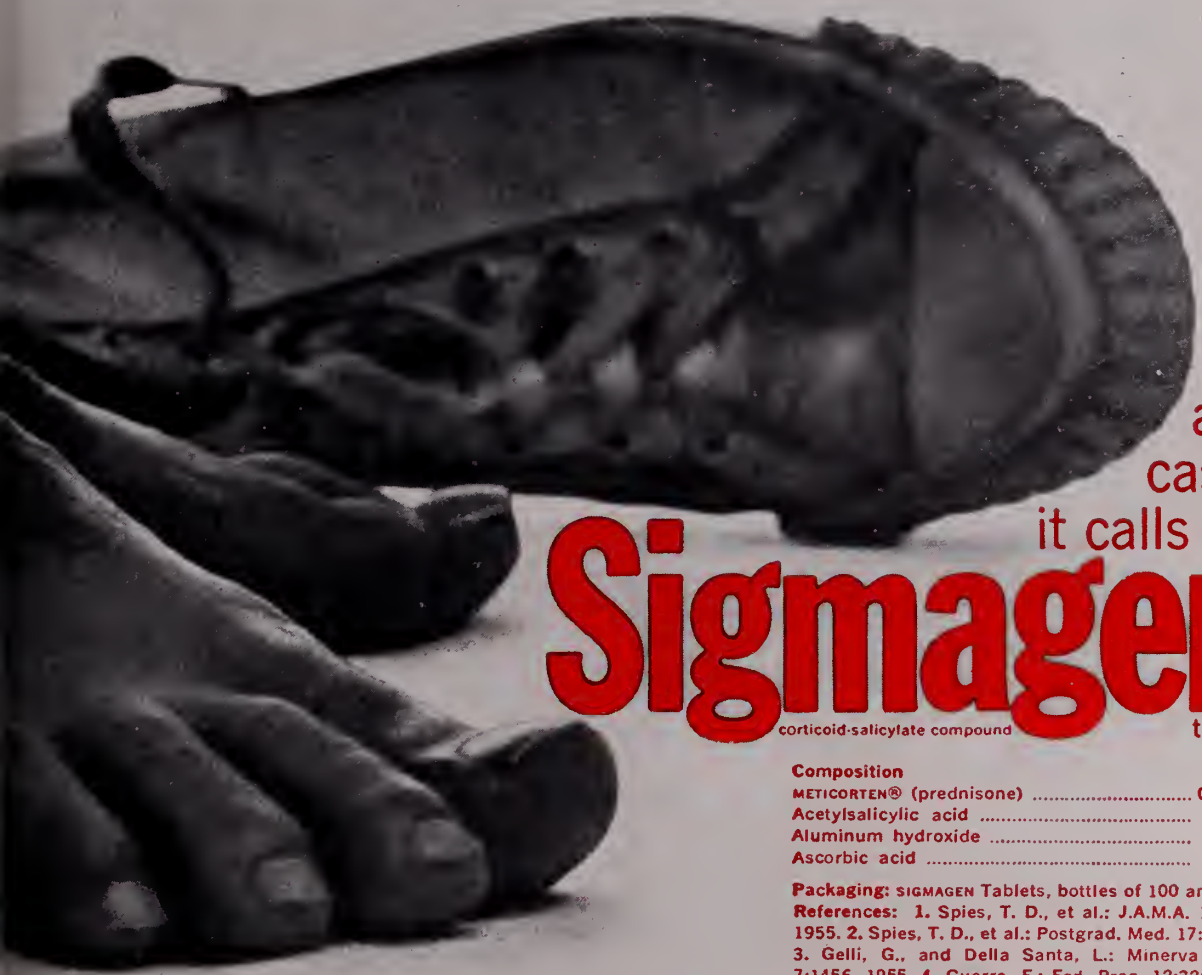
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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SG-J-61B

(Continued from page 448)

twice each week on Monday and Friday beginning at 5:15 p.m. Members of the faculty are Drs. Victor H. Kugel, director; William H. Bernstein, David A. Nathan, Milton E. Lesser, Phillip Samet and Paul N. Unger. All are from Miami Beach.

Dr. Stephen P. Gyland Sr. of Tampa has returned from Denver, Colo., where he completed a postgraduate course at the University of Colorado School of Medicine.

Dr. James T. Cook of Marianna has been reelected a member of the Board of Directors of the Florida Heart Association. Dr. Cook and Dr. Richard F. Kidder of Lake Worth have been appointed members of the Association's Clinics Committee.

A Seminar on Care of Premature Infants has been scheduled for November 17-21 at the Premature Demonstration Center, Jackson Memorial Hospital, Miami. The Seminar has been approved by the American Academy of General Practice for 35 hours credit in Category I. Information may be obtained from the Bureau of Maternal and Child Health, Florida State Board of Health, Jacksonville.

Three grants have been received by the College of Medicine, University of Florida, Gainesville, from the National Institutes of Health. One grant is for undergraduate training in psychiatry and will be administered by Dr. Peter F. Regan, III, head of the Department of Psychiatry, and the other two apply to the Department of Medicine where they will be administered by Dr. Samuel P. Martin, head of the Department, and Dr. William J. Taylor, Assistant Professor of Medicine.

A guide to the investigation and control of staphylococcal and other cross infections in hospitals is available to any hospital in the state upon request to the Bureau of Laboratories, Bureau of Special Health Services or Bureau of Preventable Diseases at the Florida State Board of Health, Jacksonville.

Dr. William H. Nass of Pensacola entered military service August 26. He is serving as a captain in the Air Force at the 38th T.A.C. Hospital in France.

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for prompt relief from emotional and somatic disturbances of ovarian decline

SUPPLIED: Bottles of 60 tablets.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods.
Should be adjusted to individual requirements.

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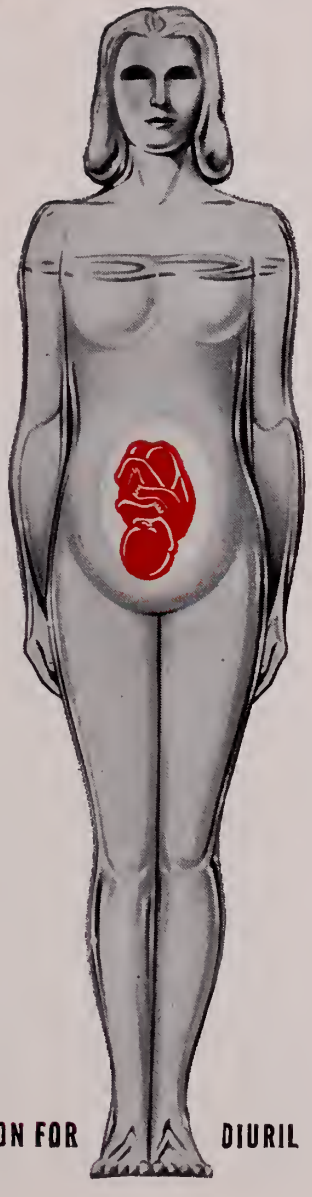
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COMPONENT SOCIETY NOTES

Alachua

Dr. Sullivan G. Bedell, of Jacksonville, chairman of the Committee on Mental Health of the Florida Medical Association, was principal speaker at the September meeting of the Alachua County Medical Society held at Gainesville. The title of his address was "What the A.M.A. and F.M.A. Is Doing About Mental Health Today." The address was part of the Society's program on mental health and was arranged by Dr. George W. Karelas, of Newberry, chairman of the Committee on Mental Health.

Dade

"Radiation Protection" was the principal topic discussed at the September meeting of the Dade County Medical Association. It was presented by the Radiological Society of Greater Miami.

DeSoto-Hardee-Highlands-Glades

Dr. Louis M. Orr, of Orlando, President-Elect of the American Medical Association, was the principal speaker at the September meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society held at the G. Pierce Wood Memorial Hospital at Arcadia. Invited guests included officers of the Florida Medical Association and members of surrounding county medical societies.

Drs. Jere W. Annis, of Lakeland, President of the Florida Medical Association, and Samuel M. Day, of Jacksonville, Secretary-Treasurer, officially represented the Association. Representing the Association and their county medical society were Dr. John M. Butcher, Sarasota, Sarasota County Medical Society, Councilor for Fifth District; Dr. Marion W. Hester, Lakeland, Polk County Medical Society, Councilor for Sixth District, and Dr. S. Carnes Harvard, Brooksville, Pasco-Hernando-Citrus County Medical Society, Chairman, Committee on Medical Economics.

Dr. Karl R. Rolls, of Sarasota, president of the Sarasota County Medical Society, joined Dr. Butcher in representing their society, and Dr. John S. Stewart, of Fort Myers, represented the Lee-Charlotte-Hendry County Medical Society.

Dr. Charles H. Kirkpatrick, of Arcadia, president of the DeSoto-Hardee-Highlands-Glades County Medical Society, presided at the meeting and introduced Dr. Orr and the other visitors. Dr. Gordon H. McSwain, also of Arcadia, secretary of the Society, was in charge of the program.



NEW! TARCORTIN LOTION
excellent for lesions of head and hands
SUPPLIED: plastic squeeze bottles, ½ oz.

1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.
5. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



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Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Duval

Dr. Louis M. Orr, of Orlando, President-Elect of the American Medical Association, will address members of the Duval County Medical Society at their first fall meeting being held October 7. The title of Dr. Orr's presentation is "The Physician and His Community." Invited guests include members of surrounding county medical societies, both Georgia and Florida.

Lake

Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, and Dr. Don C. Robertson, of Orlando, were principal speakers at the October meeting of the Lake County Medical Society.

At the September meeting held at Clermont, Mr. Ira Thomas, of the Bureau of Internal Revenue, discussed the processing of income tax returns and the operation involved in collections.

Walton-Okaloosa-Santa Rosa

Dr. Paul F. Baranco, of Pensacola, a member of the Council of the Florida Medical Association, was principal speaker at the September meeting of the Walton-Okaloosa-Santa Rosa County Medical Society held at Niceville.

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strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

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Lysine-Vitamins

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Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

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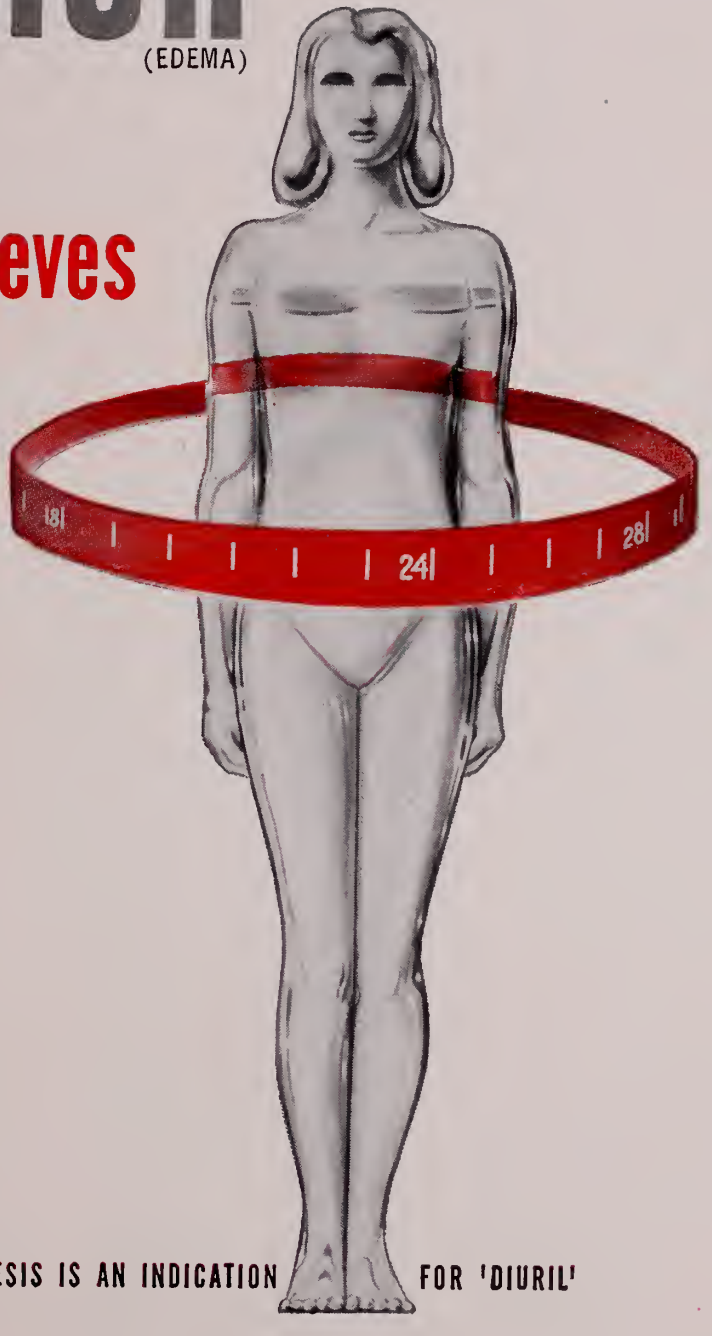
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en including
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forms:
Capsules, bottles of 16 and 100
Each capsule contains:
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equivalent to tetracycline hydro-
250 mg.
(as novobiocin sodium) 125 mg.
KM Flavored Granules. When
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hydrochloride 125 mg.
(as novobiocin calcium) 62.5 mg.
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Capsules
dult dosage is 2 capsules q.i.d.
KM Granules
treatment of moderately acute infec-
infants and children, the recom-
dosage is 1 teaspoonful per 15 to
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There is not an unlimited number of ways for Social Security to expand. Medical care is one of the few areas not covered by "social insurance," and the present framework of the Social Security Act is adequate to cover socialized medicine by means of a few amendments. The Disability Insurance "Trust" Fund could be changed into a Health Insurance "Trust" Fund by the stroke of a pen. Taxes could be increased. A new title could be added to the law and the private practice of medicine could be virtually destroyed.

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

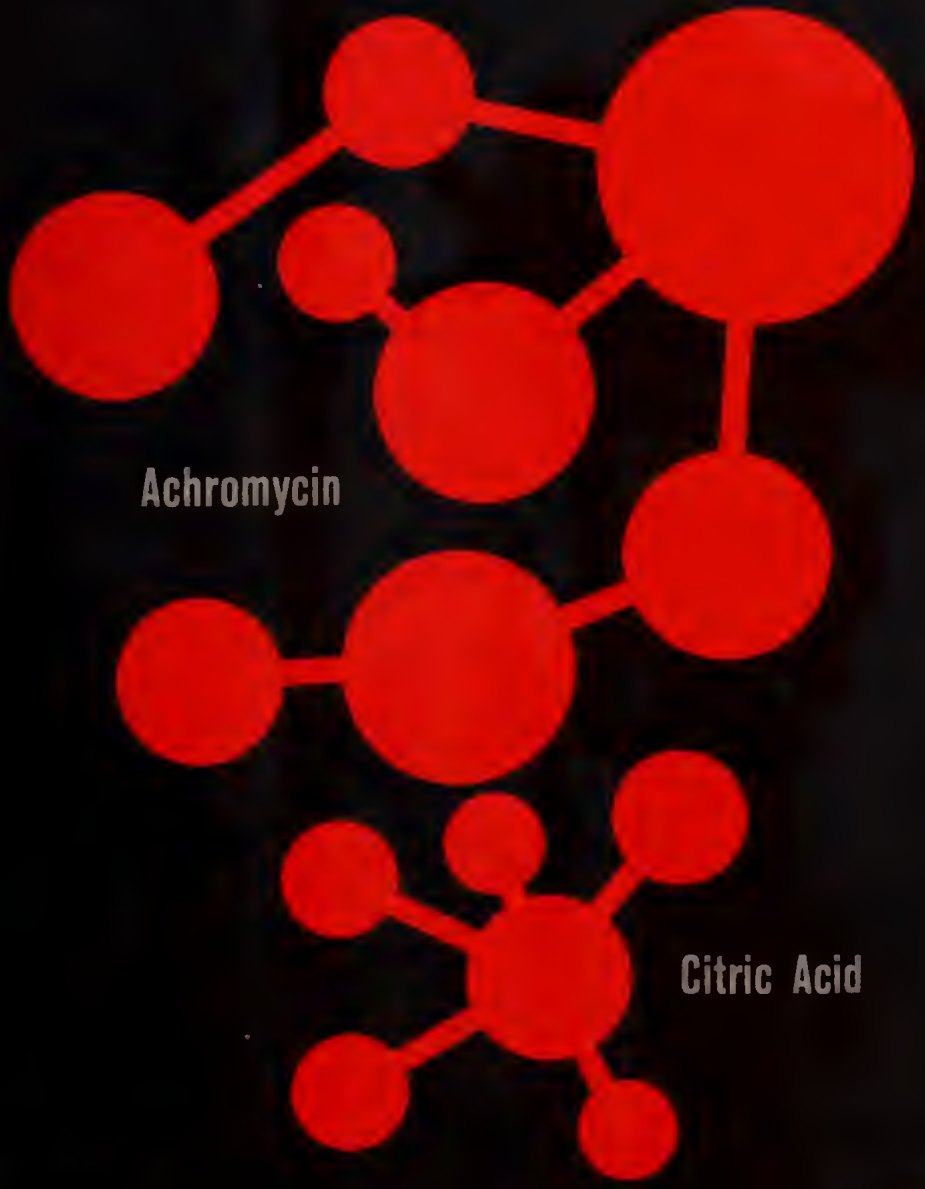
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Demerol (brand of meperidine), trademark reg. U.S. Pat. Off.

for unsurpassed performance at the clinical level . . .



Achromycin*V

What these 3 ions mean to your patients

Achromycin* V

ASSURES EVERY PATIENT PRECISE ANTIBIOTIC ACTION UNDER THE VARIED CONDITIONS OF REALISTIC CLINICAL PRACTICE

produces optimal gastric conditions

Ideally, most antibiotics are given on an empty stomach. Since citric acid helps control unavoidable variances in gastric content, conditions in the stomach are optimal with ACHROMYCIN V tetracycline with citric acid.

prevents interference with absorption

Sequestering of antibiotic molecules by free metallic ions, always present in the intestinal tract, can deprive patients of a full therapeutic dose. The three active carboxyl radicals which protect the action of ACHROMYCIN V trap these free cations and allow uninhibited antibiotic absorption.

provides for peak antibiotic action

At the site of infection where, in essence, all antibiotics are proved, ACHROMYCIN V combats a wide range of pathogens under optimal tissue conditions. Citric acid, a factor of medically established value in the natural acid base regulating mechanism of the G.I. tract, facilitates a more complete, and rapid antibiotic action.

MORE DOCTORS PRESCRIBE ACHROMYCIN V THAN ANY OTHER BROAD-SPECTRUM ANTIBIOTIC

Lederle

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abelove, William A., Miami
Alper, Louis, So. Miami
Bacon, John D., Riviera Beach
Bohn, Richard H., Coral Gables
Braverman, Leo, Miami
Carballo, Jose D., Miami
Chandler, James R. Jr., Miami
Cutler, Edward, Miami
Ferayorni, Richard R., Fort Lauderdale
Good, Raphael S., No. Miami Beach
Hoover, Richard D., West Palm Beach
Hopen, Joseph M., Hollywood
Kartub, Jack, Pompano Beach
Killinger, Raymond R. Jr., Miami
Lambert, Mark O., Indialantic
Long, Rolfe D., Vero Beach
Lowenstein, Bertrand E., Miami
McAllister, John G., Fort Lauderdale
Mazursky, Milton M., Miami Springs
Nassef, George J., West Palm Beach
Navarro, Jose I., Miami
Norton, William J., Fort Lauderdale
Pippin, Earl C. Jr., Tampa
Raim, Jerome A., Miami
Rawlings, Frederick P. Jr., Lake Wales
Roddy, Stephen R., Miami
Ruthig, Delmar W., So. Miami
Schotz, Sylvan A., Miami Beach
Sorel, Otto G., Melbourne
Thames, Thomas B., Orlando
Tocci, Frank P., Fort Lauderdale
Trumbo, Robert B., Orlando
Wendland, Robert P., Pompano Beach

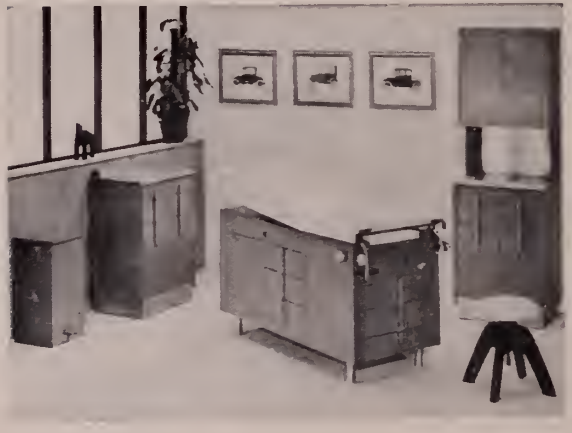
OBITUARIES

William Steinman

Dr. William Steinman of Miami died on Feb. 10, 1958. He was 41 years of age.

Born in Chicago on Sept. 19, 1916, Dr. Steinman attended the University of Illinois and in 1939 was awarded the M.D. degree by the College of Medicine of that institution. Following an internship in Cook County Hospital in Chicago, he served overseas with the Army Medical

The distinctive PREMIERE suite



By Hamilton

Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere—and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basis and pull-out step are included.

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Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."

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Dihydroxy aluminum aminoacetate, N.N.R.

In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

BRAYTEN PHARMACEUTICAL COMPANY • *Chattanooga 9, Tennessee*



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Corps in World War II. Upon his release from military service, he engaged in special training in ophthalmology, completing a postgraduate course at Harvard Medical School and serving a residency in Cook County Hospital. His medical fraternity was Phi Delta Epsilon.

In 1948, Dr. Steinman located in Miami and for 10 years was active in the practice of his specialty in that community despite a prolonged struggle against ill health. He was serving as president of the Greater Miami Eye, Ear, Nose and Throat Society at the time of his death and was also president of the South Florida Hospital Corporation, an organization dedicated to the building of a new hospital.

Dr. Steinman was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. In addition, he was a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology and Otolaryngology.

Surviving are the widow, Mrs. Elaine Steinman, a daughter, Brenda, and a son, Sanford, all of Coral Gables. His mother and three sisters also survive.

Samuel Glen Hollingsworth

Dr. Samuel Glen Hollingsworth of Bradenton died of bronchial pneumonia in that city on July 13, 1958, after a lengthy illness. He was 87 years of age.

Born in Brazil, Ind., on June 10, 1871, Dr. Hollingsworth received his medical training at Hering Medical College in Chicago, where he was graduated in 1897. He practiced medicine in Brazil for 15 years before coming to Florida. In 1913 he located in Bradenton and continued to practice there until he retired in 1953.

Locally, Dr. Hollingsworth was active in civic affairs through the years. He was the first president of the Bradenton Country Club and the second president of the Kiwanis Club. From 1942 until 1945 he was school physician and from 1945 to 1953 he served as clinic physician for the County Health Department.

Dr. Hollingsworth was a member of the Florida State Board of Medical Examiners for more than 20 years, relinquishing that post upon retirement in 1953. He was a member of the Manatee County Medical Society and a life member of

(Continued on page 480)

Aluscop
CAPSULES

ANTICHOLINERGIC • ANTISECRETORY • ANTI-ENZYME • ANTACID

with a medical splint

Aluscop capsules, a unique preparation equally as effective as the liquid form, provide rapid and prolonged relief of pain, discomfort and dysfunction in the management of peptic ulcer, hyperacidity, gastro-intestinal spasm or hyperirritability.



Aluscop TREATS THE ENTIRE DYSPEPTIC SYNDROME

- **Methscopolamine nitrate**—the most potent antisecretory agent—35 times that of atropine sulfate, inhibits gastric acid secretion and acts as a "medical splint" through its visceral antispasmodic action.
- **Dihydroxy aluminum aminoacetate and magnesium hydroxide**—two of the most effective antacids—exert dual action without constipating effect.
- **Sodium lauryl sulfate**—a pepsin inactivator—minimizes pepsin erosion and further destruction of tissue to hasten healing of lesions.

Composition: 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

Dosage: 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

Supplied: Bottles of 100 capsules and 12 oz. of suspension.

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Fine Pharmaceuticals Since 1894

Faster rehabilitation in a

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



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Rheumatoid Arthritis

multiple compressed tablets

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THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



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MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

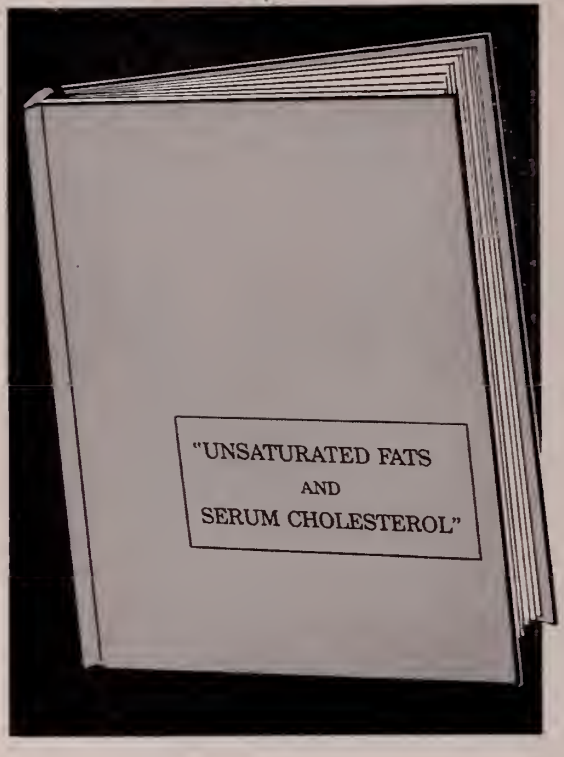


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A review of the latest concepts and results of current research



This new book contains the most up-to-date bibliography of current research on: 1. The origin and behavior of cholesterol in the human body; 2. The effect of different dietary fats on serum cholesterol levels; 3. The nature of the active components in vegetable oils; and 4. Suggestions for practical diets.

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Provides approximately:

LINOLEIC ACID	**7.4 Gm.**
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Total unsaturated Fatty Acids—85%

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 Tbsp.
For a 3000 calorie diet	2.5 Tbsp.
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Comments by investigators on

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Robins



– the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

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Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104	28	4	2
		(75.3%)	(20.3%)		

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
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"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

BONADOXIN®

STOPS MORNING SICKNESS, BUT..

Highest percentage of relief: In *Drugs of Choice*[1], clinical data on several therapies for nausea and vomiting of pregnancy is summarized. BONADOXIN afforded the highest percentage of relief in the "excellent" (79%) and "good" (16%) combined categories. The majority of cases were completely controlled in the first week of treatment, almost all on one tablet nightly.





Safe, too:
BONADOXIN doesn't "stop" the patient. It is free of side effects commonly associated with overpotent antinauseants. Goldsmith, reporting on 620 controlled cases, states that "toxicity and intolerance [are] zero."[2]

BONADOXIN

DOESN'T STOP THE PATIENT!

Now
available in tablet or drop form.

Dosage: usually one tablet or one tsp. (5 cc.) at bedtime. Severe cases may require another dose on arising.

Supplied: tiny pink-and-blue tablets, bottles of 25 and 100. Bonadoxin Drops in 30 cc. dropper bottles.

Each tiny pink-and-blue Bonadoxin tablet contains:
Meclizine HCl (25 mg.)
...for symptomatic relief
Pyridoxine HCl (50 mg.)
...for metabolic action and prompt antinauseant effect.

Infant colic?
Non-narcotic Bonadoxin Drops stop colic in about 85% of cases.
Each cc. contains:
Meclizine Dihydrochloride...8.33 mg.
Pyridoxine Hydrochloride...16.67 mg.

Dosage:

under 6 months	0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years	1.5 to 2 cc.	
2 to 6 years	3 cc.	
adults and children over 6 years	1 teaspoon (5 cc.)	

Supplied:
fruit-flavored, clear green syrup in 30 cc. dropper bottles.

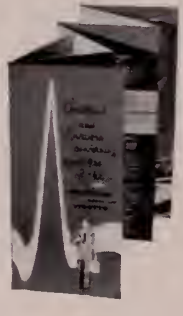
References: 1. Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347. 2. Goldsmith, J. W.: Minnesota Med. *40*:99 (Feb.) 1957.

NEW YORK 17, N. Y. | DIVISION, CHAS. PFIZER & CO., INC. SCIENCE FOR THE WORLD'S WELL-BEING



ANSWERING DOCTORS' QUESTIONS . . .

about the SANBORN Model 300 Visette electrocardiograph



The text and pictures in this new 12-page booklet tell the story of the Sanborn Visette ECG in a unique way: *as answers to actual questions asked by hundreds of doctors* — at medical conventions, in correspondence, in conversations with Sanborn people. Many of these questions are probably ones you might also ask, to get a clear picture of just how a Visette might fit into *your own* practice and diagnostic procedures. Here are facts *you* can use, presented from the *doctor's* point of view.

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The familiar Model 51 Viso Cardiette — in use today throughout the world — is available as always. This larger, heavier (34 lb.) instrument is the "office standard" in thousands of practices. Price $785 delivered.



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PREVENT
both cause and fear of
ANGINA ATTACKS

proven safety for long-term use



Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with

MILTOWN®

The *original* meprobamate, discovered and introduced by Wallace Laboratories

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sustained coronary vasodilation with

PETN

pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 13D

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

CML-7186

®WALLACE LABORATORIES, *New Brunswick, N. J.*

*TRADE-MARK



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

(Continued from page 470

the Florida Medical Association, having held membership in the Association for 42 years. He also held membership in the American Medical Association.

Survivors include two sisters, Mrs. Mabel Otis, of Defiance, Ohio, and Mrs. Helen H. Bard, of Bradenton. Dr. Hollingsworth's wife preceded him in death in 1957.

George Hilliard Warren

Dr. George Hilliard Warren died at his home in Perry on May 30, 1958, after a long illness. He was 81 years of age.

Dr. Warren was born in Orchard, Ill., in 1877. He received his medical training at St. Louis University of Medicine, where he was graduated in 1904. After completing an internship, he entered the private practice of medicine in Camp Cristy, Ky. In 1912 Dr. Warren came to Florida to be the doctor for a lumber company in the former sawmill town of Springdale. Two years later he moved to Perry, where he continued to practice for more than 40 years, until ill health necessitated his retirement some three years ago. Devoted to his profession and active in civic affairs through the years, he was one of Perry's most beloved citizens.

Dr. Warren was a member of the Taylor County Medical Society for many years. He held membership in the Florida Medical Association for more than three decades and was also a member of the American Medical Association.

In 1907, Dr. Warren was married to the former Judia Williams, who survives him. Other survivors include two sons, Frank Warren, of Perry, and Dr. Kenneth W. Warren, a surgeon of Boston, Mass.; six grandchildren; and one sister.

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ARTHRITIS... OR GOUT?



BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

GOUT—THE DIAGNOSTIC PROBLEM

Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

BENEMID®—AN EFFECTIVE URICOSURIC AGENT

'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

MSD MERCK SHARP & DOHME

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These flavor tips keep the taste in when you take the fat out of your patient's diet

The Low-Fat Low-Cholesterol Diet

—and with your consent, a glass of beer for a morale-booster

● Cranberry and tomato sauce pinch-hit for gravy. Herbs and spices lend a fine aroma to meats and vegetables. Chicken can be basted with lemon or orange juice. Meat loaf may sport a gay cap of whole-cranberry sauce while "surprise" hamburgers can hide a slice of pickle or onion sealed between two thin patties. And kabobs can add something different. On green salads, cottage cheese thinned with lemon juice makes the dressing. For dessert, angel cake goes nicely under fruits—skim milk powder makes the "whipped cream."

And with a glass of beer*—at your discretion—your patient will find his diet interesting and ample without straying from your instructions.

*Fat—0; Calories 104/8 oz. glass (Average of American Beers)

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Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

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'EMPIRIN' COMPOUND®

WITH

CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations



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gr. 1



gr. ½



gr. ¼



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Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*



Codeine Phosphate . . . . . gr. ½
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

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Codeine Phosphate . . . . . gr. ½
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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'EMPIRIN' COMPOUND®



Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½
Caffeine . . . . . gr. ½

...from mild pain complicated by tension and restlessness.

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*Subject to Federal Narcotic Regulations

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Rx why California table wine in the low-sodium diet?

TABLE I[1]

	Na. specimens examined	Sodium (mg./100 cc.) Mean
Musts (crushed white grapes)	9	1.63
California Red Table Wines	82	5.56
California White Table Wines	73	5.44
California Dessert Wines	104	7.10

*D*ietary restriction of sodium has become a standard procedure in the control of edema associated with cirrhosis of the liver, congestive heart failure, certain kidney ailments, toxemias of pregnancy, during digitalization and in drug-induced diuresis.

Unfortunately sodium-restricted diets tend to be flat, tastcless, monotonous, leading toward failure of dietary cooperation by the patient.

In such cases California table wine may be employed safely as well as to advantage in making the food more palatable without adding significant amounts of sodium .

In a recent study[1] it was shown that California table wines are remarkably low in sodium content—less than 10 mg. per 100 cc. (3½ ounce glass).

Since recent research [2,3,4] has also shown that wine stimulates a lagging appetite and aids digestion while adding a sparkle to any meal—why not encourage the moderatc use of wine by the patient on a restricted dietary, as well as by the sufferer from anorexia, the post-surgical, convalescent or geriatric patient?

May we send you a copy of "Uses of Wine in Medical Practice"? A copy is available to you, at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Lucia, S. P. and Hunt, M. L.: Am. J. Digest. Dis. 2:26 (Jan.) 1957.
2. Gaetzl, F. R.: Permonente Found. M. Bull. 8:72 (April) 1950.
3. Irvin, D. L. and Goetzl, F. R.: Permonente Found. M. Bull. 9:119 (Oct.) 1951.
4. Irvin, D. L.; Durro A., and Gaetzl, F. R.: Am. J. Digest. Dis. 20:117 (Jan.) 1953.

WOMAN'S AUXILIARY
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State Board Meeting and Conference

On October 21-22 at the Whitehall Hotel in Daytona Beach, the State Board Meeting and Conference will be held. The Daytona Beach Auxiliary, Volusia County, along with the State Committee Chairman, will serve as hostesses. The theme of this meeting will be the "Auxiliaries in Action." This theme gives the impression that things are moving at a rapid pace which is exactly correct, as new president, Ann Rogers, goes into action to get every one interested in making this a big and successful year in Auxiliary work.

The aim of the meeting is "to get as many local officers and committee chairmen present as possible." The Conference is being planned to help these officers and others build their years' activities around the use of Auxiliary projects in carrying out good programs at meetings and in better serving their communities.

Several methods and ideas for the fall conference are being utilized, such as skits, films, panel discussions, interest groups, flip charts, exhibits and library table. Members will be divided into interest groups to help with new ideas and materials for the year. Much preparation and planning have gone into the organization of this meeting and it will be interesting to everyone. We are sending this article as a special request to each physician to send his wife to the meeting. It will be an inspiration to each of us and we will return home with renewed interest and enthusiasm to carry out the aim "Auxiliaries in Action."

Following is a schedule of the Board Meeting and Conference.

October 21

1:00-2:00	Registration
2:00	Conference
4:30-5:30	Interest Groups
5:30-7:00	Social Hour
7:00	Dinner and Fashion Show
8:30	Evening free for fun





all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

Each* Tussagesic *Tablet contains:

Triaminic®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-para-aminophenol)	325 mg.

To reduce upper respiratory congestion and irritating secretions.

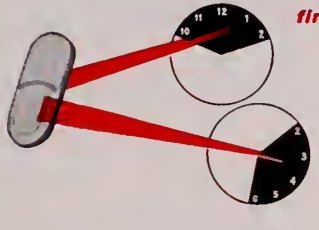
For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

For specific, highly effective antipyresis and analgesia.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.



first—3 to 4 hours of relief from the outer layer

then—3 to 4 more hours of relief from the inner core

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Tussagesic suspension

NEW

Tussagesic

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October 22

9:00	Conference
10:00	Refreshments
11:00-1:00	Board Meeting — Official Business
1:00	Luncheon — Dr. Louis M. Orr, Speaker

The finale and highlight of the second day will be the luncheon at which Dr. Louis M. Orr, President-elect of the American Medical Association, will be guest speaker. We are fortunate to have Dr. Orr with us and we will be looking forward to his address.

I hope to see each and everyone of you at this meeting. Remember we are all needed! It takes all of us to do the job. Remember, Doctors, we are counting on you to send your representatives, too!

Mrs. Albert F. Stratton Jr.

BOOKS RECEIVED

Drugs, Their Nature, Action and Use. By Harry Beckman, M.D. Pp. 728. Price, $15.00. Philadelphia, W. B. Saunders Company, 1958.

This new and manageable pharmacologic reference provides an uncluttered presentation of the action of various classes of drug agents the physician employs frequently. Coverage progresses according to logical physiologic units - first, drugs that stimulate or depress muscle, next, drugs relating to blood and the blood vessels, and then those affecting the central nervous system. The combined discussions of the actions and actual uses of drugs in an arrangement designed for direct serviceability from the pharmacotherapeutic standpoint make it relatively simple for the physician to locate the most effective drug for the effect he wishes to produce in a particular area or system of the body. The most important drugs in each class are all included—with notations as to indications, contraindications, dosage, toxicity, side effects and other considerations. This volume is an excellent textbook for the undergraduate medical student, who has little time to prepare for the pharmacologic aspects of the practice that lies ahead.

Dr. Beckman, the author, is Director of the Departments of Pharmacology, Marquette University Schools of Medicine and Dentistry, and Consulting Physician to the Milwaukee County General Hospital and Columbia Hospital, Milwaukee, Wisc.

Memoirs of a G.P. By Otis Marshall, M.D. Pp. 155. Price, $3.50. New York, Vantage Press, 1958.

Here, vividly told, is the life story of a real "horse-and-buggy" doctor, one of that race of heroes who knew the general practitioner's life as it was in the days before x-ray machines, laboratory tests, sulfonamides, pencillin and staffs of trained assistants. He and his contemporaries set broken bones, used dining room tables for operating tables, treated burns, cuts, bullet wounds, ordinary ills and critical conditions, battled raging epidemics and brought hundreds of thousands of babies—in "house deliveries"—into this world. No hour, day or night, was the doctor's own, no crisis too great for him to face—alone. "Life was hard," concedes the author, "but as long as we didn't worry, we doctors made it very well."

The years brought revolutionary changes in medical practice, and Dr. Marshall grew along with his profession,

(Continued on page 494)

...to postpone the "G" point*...

℞.....Geritag

For patients over 40, The G POINT (point of declination in life) can be postponed!

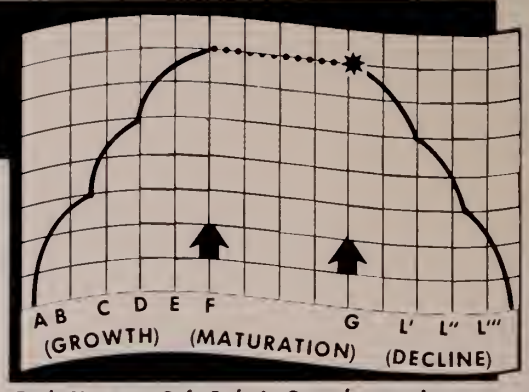
Properly balanced Androgen — Estrogen — nutritional therapy may prevent premature aging and damage of gonadal decline and nutritional inadequacy.

Complaints of symptoms such as muscular pain, fatigue, irritability, and poor appetite in the patient over 40 may be the first indications of three major stress factors in the aging process: (1) Gonadal Hormonal Imbalance, (2) Nutritional Inadequacy and (3) Emotional Instability. GERITAG is especially formulated to guard against premature damage and to delay the degenerative process.

Rx GERITAG in preventive geriatrics.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Copper	0.2 mg.	Zinc	1 mg.
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q. 12 h.

Two capsules on arising **last all day**
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relieve nervous tension on a *sustained* basis, without between-dose interruption

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Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

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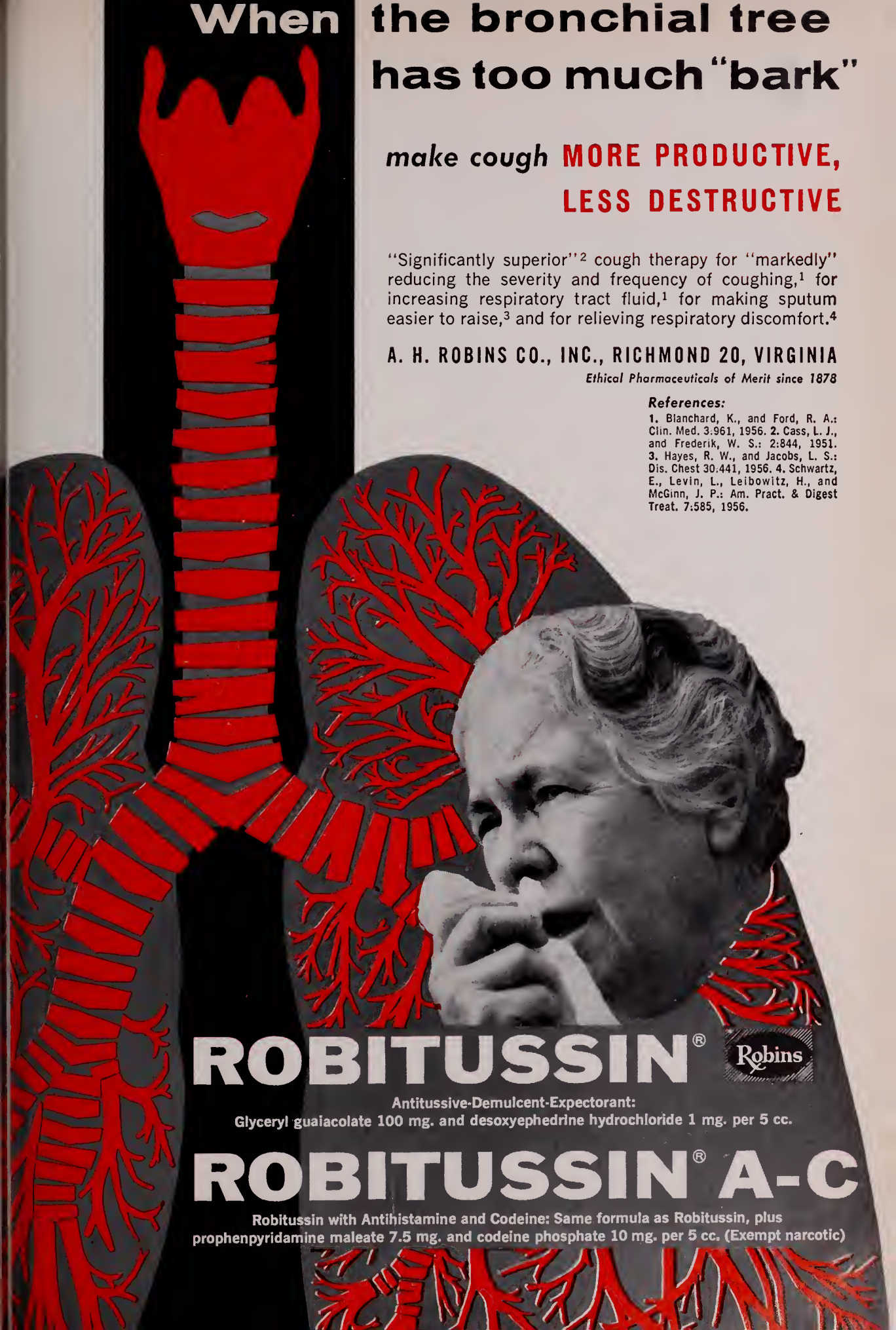
"Significantly superior"[2] cough therapy for "markedly" reducing the severity and frequency of coughing,[1] for increasing respiratory tract fluid,[1] for making sputum easier to raise,[3] and for relieving respiratory discomfort.[4]

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References:

1. Blanchard, K., and Ford, R. A.: Clin. Med. 3.961, 1956. **2.** Cass, L. J., and Frederik, W. S.: 2:844, 1951. **3.** Hayes, R. W., and Jacobs, L. S.: Dis. Chest 30.441, 1956. **4.** Schwartz, E., Levin, L., Leibowitz, H., and McGinn, J. P.: Am. Pract. & Digest Treat. 7:585, 1956.



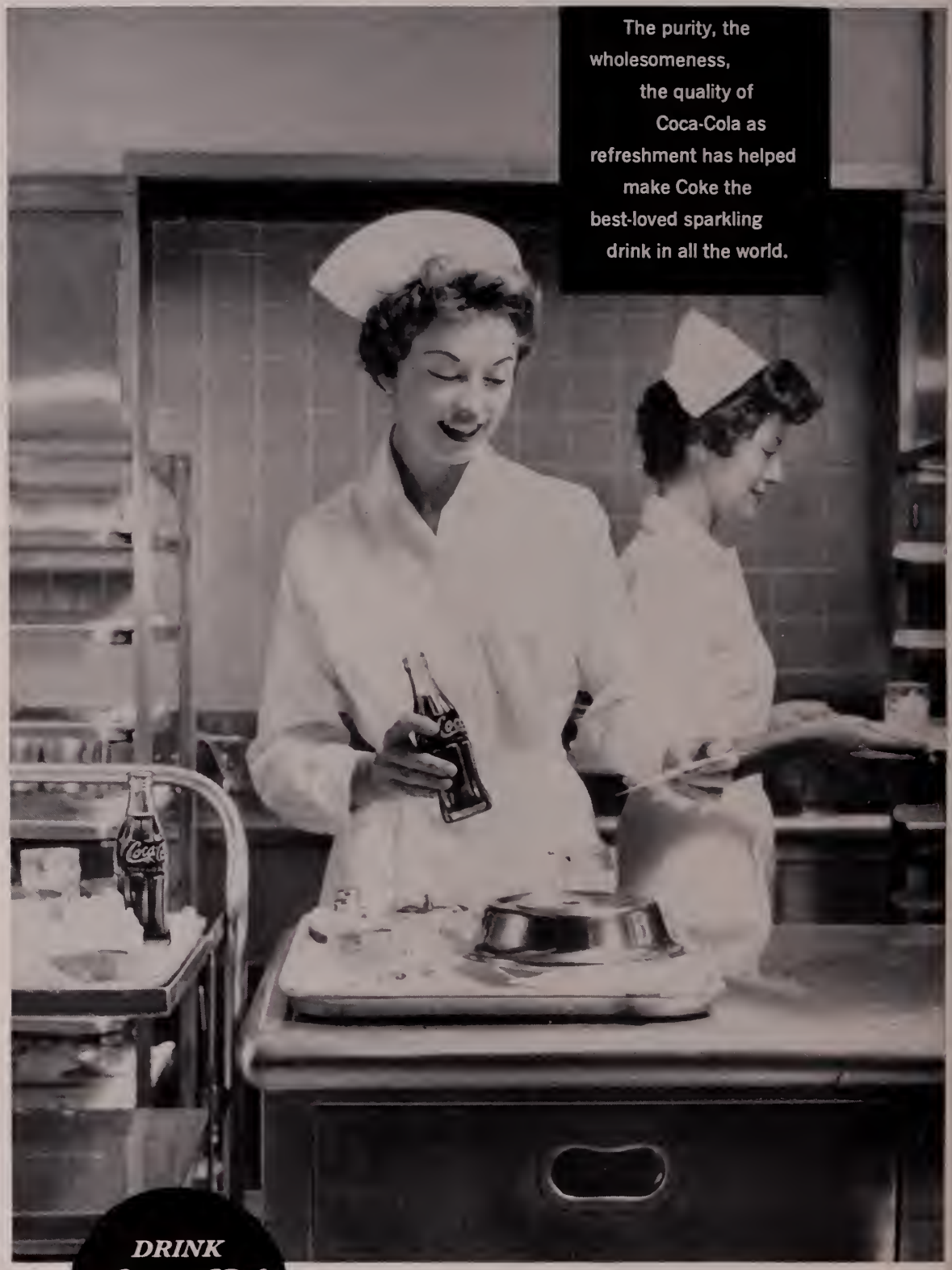
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(Continued from page 486)

always learning, with a never dimming devotion to his calling—and his recent years have been as exciting as his first months of practice. It is all here, graphically narrated: doctor in a coal-mining camp; "country doctor" in Culpeper, Va.; industrial practice; service all over the United States for the American Red Cross; and director of the clinic and medical service at Penney Farms, Fla., one of the first research centers for that rapidly expanding field, geriatrics. Warmth and humanity glow in these pages. To read of this G.P.'s life of service brings comfort in the knowledge of its existence, and hope for the future because such courage and selflessness are part of the American tradition.

Dr. Marshall is a loyal son of the Old Dominion, a graduate of the University of Virginia Medical School—"The University"—which this year honors him as a "patriarch" for his 50 years of service to medicine. In recent years he has held membership in the Duval County Medical Society and the Florida Medical Association. Now in "active retirement," he lives in Asheville, N. C., and spends his winters in Florida. He finds that "life is still wonderful—and there is still so much to do."

Atomic Energy in Medicine. By K. E. Halnan, M.D., D.M.R.T. Pp. 158. Price, $6.00. New York, Philosophical Library, 1957.

One of the most important applications of atomic energy is its use in the field of medical science. The use of radioisotopes has revolutionized many aspects of medical research and diagnosis. These materials are also invaluable aids in a growing number of types of medical therapy. Dr. Halnan in this book covers these fields in some detail clearly and authoritatively, describing at the same time the background of nuclear physics against which each aspect of this new field of atomic medicine must be set if it is to be truly understood. He writes for readers not necessarily having much knowledge of either physics or medicine as he presents a most useful introduction to an interesting new field of medicine. The subjects covered in the 11 chapters are: introduction to atomic physics and the nuclear reactor; the principles of use of radioactive isotopes; radioactive isotopes in medical research; radiobiology; cancer and radiotherapy; radioactive iodine and the thyroid gland; radioactive isotopes and blood diseases; other new aids to diagnosis; the medical use of high energy particle accelerators; problems and hazards of radiation, and the future.

The Adjuster's Manual; *For Evaluation of Accident and Sickness Claims.* By Paul V. Reinartz, M.D. Ed. 6. Pp. 514. Price, $10.00. Philadelphia, Chilton Company, 1958.

Now in its sixth edition, this classic guide for evaluating accident and sickness claims has been enlarged, newly illustrated, and completely rewritten. It is especially planned and organized for use by adjusters, home office personnel, personnel managers, attorneys, and laymen in the entire field of Health Insurance and Life Insurance. Reflecting not only developments but also changes in procedure and technic over the last 10 years, this reliable book covers the medical aspects of claim adjustment in nontechnical language and applies its carefully researched material to the evaluation of claims that arise under health and accident policies. It also gives finger-tip knowledge on disabilities resulting from sickness and injury.

For the individual adjuster in the field, the Manual is the most comprehensive reference available in easy-to-use form and handy format. Drawing on over 20 years' experience, the author shows how to adjust claims arising from injuries to and diseases of the body, from abrasions, contusions, incisions, lacerations, puncture and penetrating wounds, burns, sprains, dislocations, fractures, amputations, and miscellaneous injuries; from acute infectious or contagious diseases, circulatory diseases, respiratory and digestive diseases, liver and kidney and bladder diseases; from diseases of the brain and the

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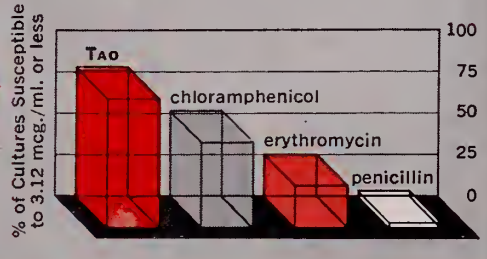
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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nervous system, orthopedic conditions, diseases of the skin, ear, eye, and nose. Included are entirely new sections on rectal disorders, male genitourinary conditions, and gynecologic disorders, as well as information on many miscellaneous physical impairments, such as diabetes, goiter, gout and poisoning. The book is illustrated by 117 new photographs and drawings.

Dr. Reinartz, who is Medical Director of the South-Central Home Office of the Prudential Insurance Company of America and a member of the Florida Medical Association, explains in the Preface that the disability patterns suggested in the text are as physicians would tend to know them and that the motive is to lend aid and to instruct rather than to dictate or in any manner obstruct the rightful adjustment of legitimate claims.

Nuclear Energy in the South. Edited by Redding Sugg Jr. Pp. 151. Price, $3.50. Baton Rouge, Louisiana State University Press, 1957.

This book blueprints the coming Atomic Age in the South from the present to 1975. During this period the nation will enjoy a new phase of growth and power, one in which nuclear energy will transform industry, engineering and agriculture, and bring miraculous advances in medicine and public health. Convinced that the economic future of the South lies at the heart of the atom, the Southern governors delegated the Southern Regional Education Board to prepare the present business-like study. Most of the material here summarized or reproduced may be found in the working papers mimeographed by the Southern Regional Education Board in two volumes entitled "Work Conference on Nuclear Energy, St. Petersburg, Florida, August 1-4, 1956." The first chapter deals with nuclear energy in relation to the production of electric power in the South. The next three are about the uses to which the by-products of nuclear fission—heat and radiation—may be put, and indeed are being put, in general industry, agriculture, and medicine and public health, with special reference to Southern conditions. In the concluding chapter, trained manpower and the program required to supply it are presented as essential to any significant development of nuclear science and industry in the South. The recommendations which the governors endorsed in each of these fields appear at the conclusion of each chapter.

Nuclear Radiation in Medicine and Public Health is the subject of Chapter IV. Part One, Medical Applications of Nuclear Energy, was prepared by H. D. Bruner, M.D., Professor of Physiology, Emory University. Part Two, Nuclear Development and Public Health, and the section on Implications for Medical Education were prepared by Clinton C. Powell, M.D., Special Assistant for Radiological Health, Division of Special Health Services, U. S. Public Health Service.

Surgery in World War II. Ophthalmology and Otolaryngology. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for Ophthalmology, M. Elliott Randolph, M. D.; Editor for Otolaryngology, Norton Canfield, M. D.; Associate Editor, Elizabeth M. McFetridge, M. A. Pp. 605. Washington, D. C., Office of the Surgeon General, Department of the Army, 1957.

This most recently published volume of the official history of the Medical Department, United States Army in World War II, records the outstanding services rendered by ophthalmologists and otolaryngologists in that conflict. The section on ophthalmology is based on the work and experience of the chiefs of the Ophthalmology Branch in the Surgeon General's Office, the overseas consultants, and medical officers concerned with problems related to the eye. It is a record of administrative phases and the clinical aspects of ophthalmology, as reflected in the policies and practices concerned with both the specialty and its associated activities, such as the optical and artificial eye programs and, most significantly, the program for the rehabilitation of blinded casualties. The section on otolaryngology sets forth the general statements of policy and specific details of important phases of combat otolaryngology. One particularly interesting feature of this volume is the story of the development of new technics, such as the development of acrylic eyes and the management of selected cases of psychogenic deafness by narcosynthesis.

The book will be of great interest to all medical officers who served in this country and overseas, whether they have returned to civilian life or are still in the Army. It will also be of interest to the medical officers who served in Korea, the story of whose experience will eventually be officially recorded. In addition, the volume will serve as a source of information and inspiration to the young men now in medical school whose future will almost inevitably include a term of service in one of the medical services of the Armed Forces.

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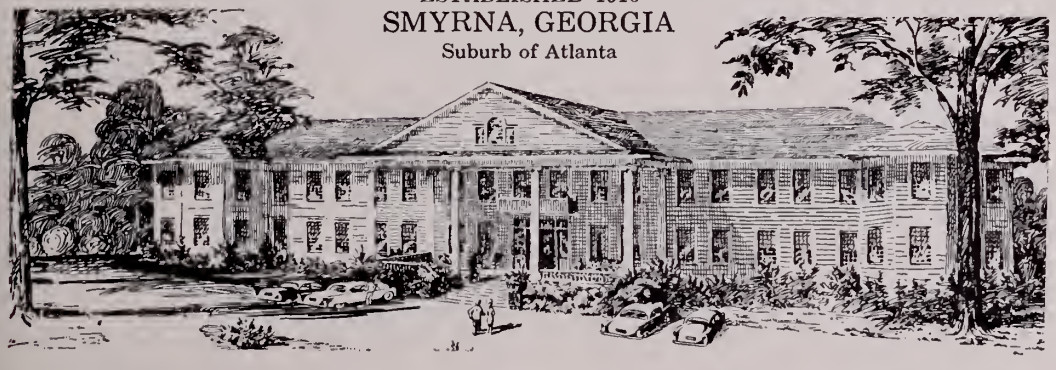
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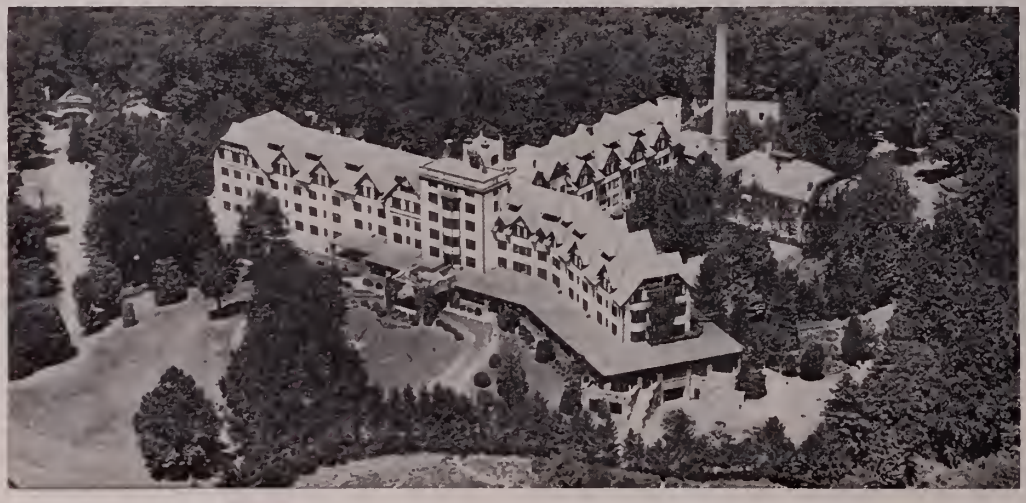
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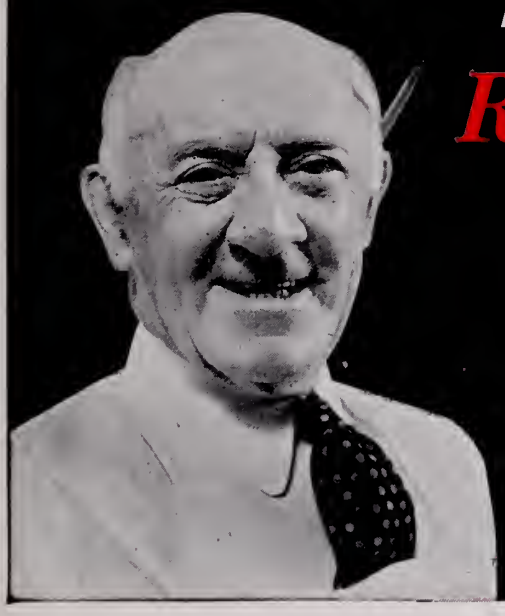
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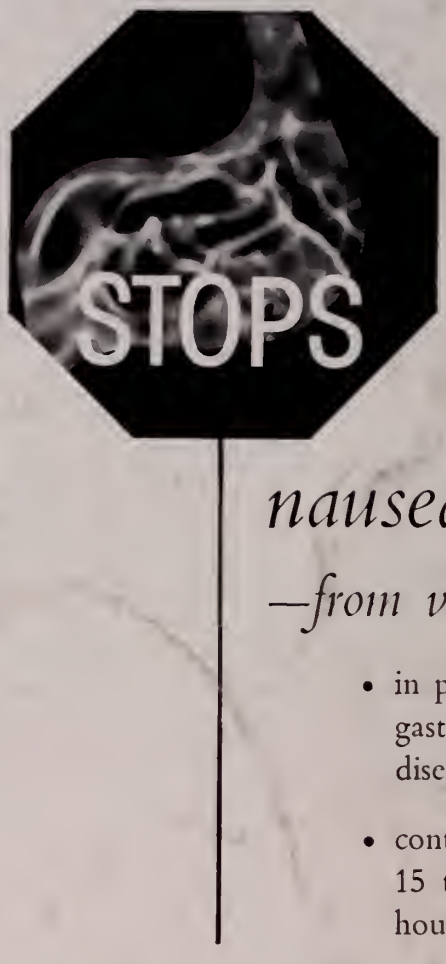
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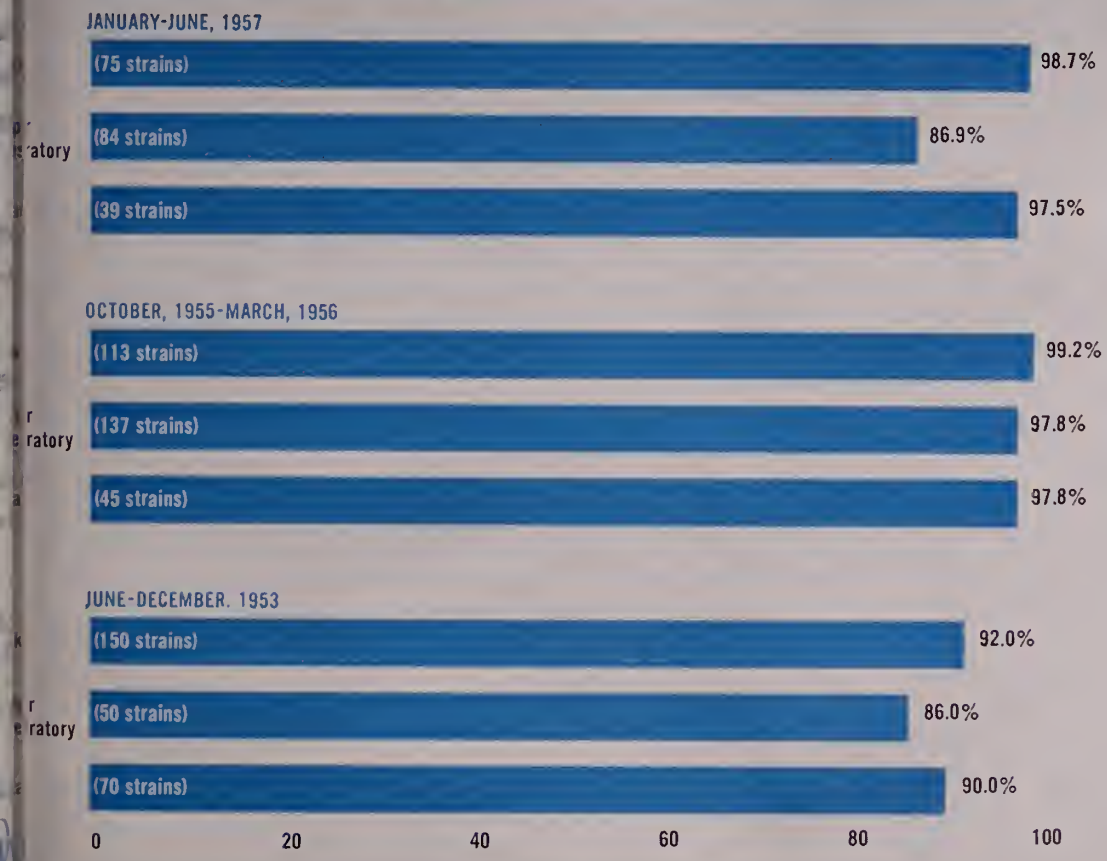
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(1) Hartedorn, A. B. Proc. Staff Meet. Mayo Clin. **32** 705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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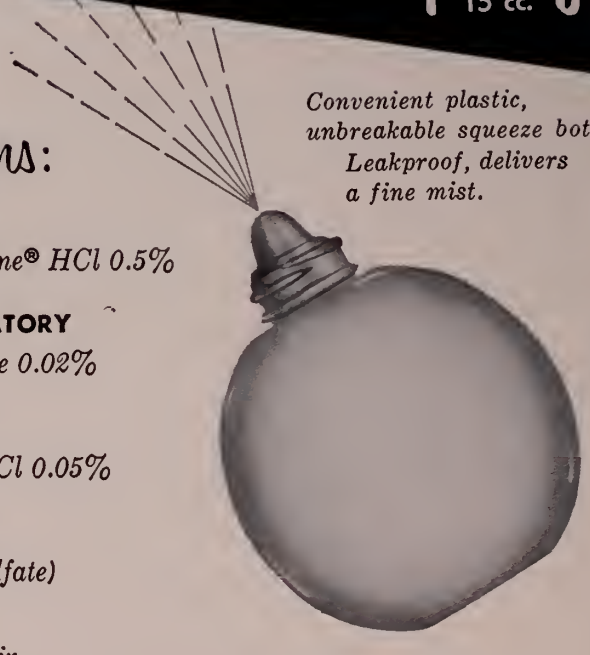
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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:395, March 1958.
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:504, Dec. 1957.

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3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
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2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
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5	12	21	4	6½	5	768
6	13	22	4	7	5	812
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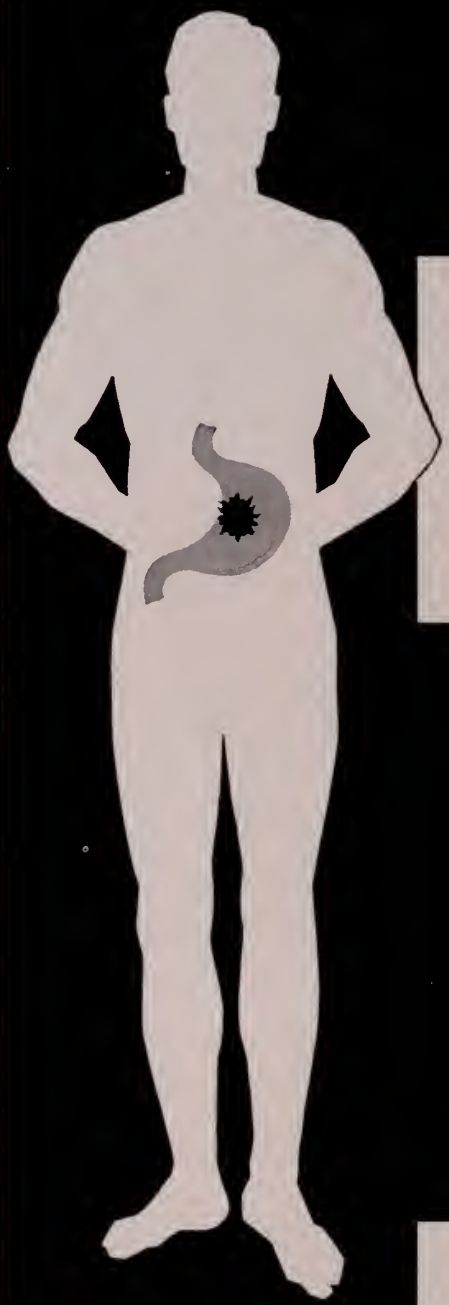
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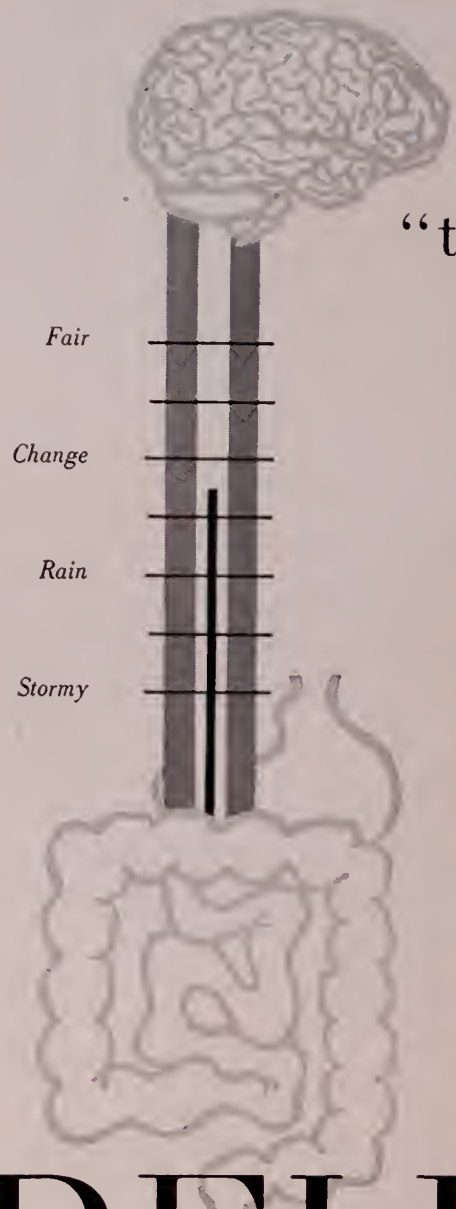
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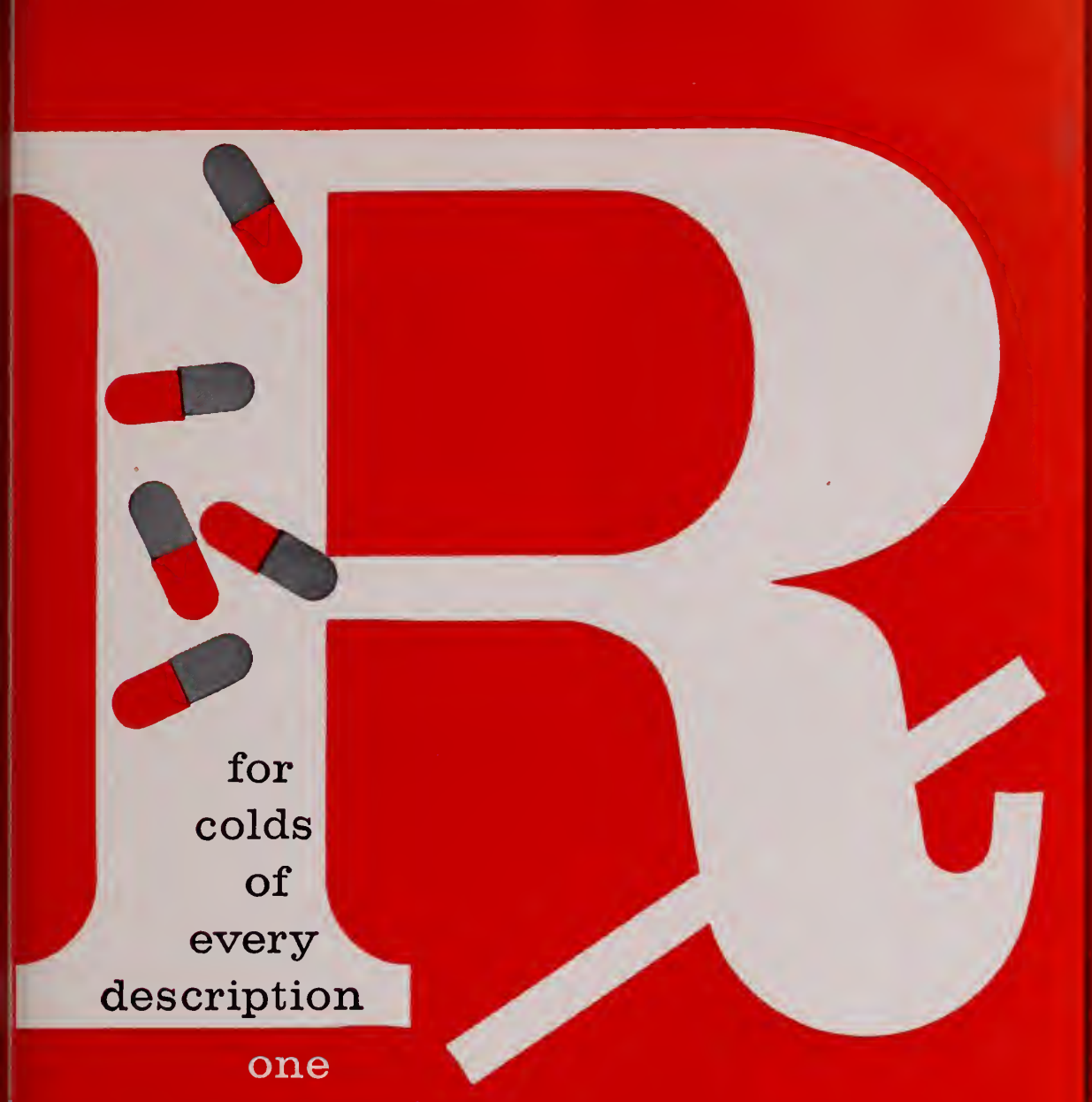
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The Journal of the Florida Medical Association
PUBLISHED MONTHLY

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An Analysis of the Causes Of Blindness in Florida

NATHAN S. RUBIN, M.D.
PENSACOLA

This address marks a pioneering effort to analyze the causes of blindness in Florida from an examination of the medical records of a segment of its blind population. Hitherto, all data have been derived from compilations* of doubtful value because information concerning causes was given by lay people, or from Social Security Bulletins which estimate the number of blind in the various states by an ingenious statistical formula. As of July 1, 1952, this formula estimated Florida's blind to be 1 in 400.[1]

In July 1937, when the Florida Legislature enacted the laws which brought the present Blind Assistance Program into operation, a standard definition of blindness** was adopted, the fact of blindness was determined usually by an ophthalmologist, and a medical record was made. These eye examination records, containing diagnoses and descriptions as complete as possible of the origin of the defective vision of all persons approved for Aid to the Blind from 1947 to 1957, form the major basis for this analysis. Also included are eye records of a group of children who had sought the services of the Florida Council for the Blind during this same period.

Since these medical records are derived almost altogether from persons at an economic level of indigency, and are limited in the number of youth, there may be some question as to how representative of the total blind population in Florida these data are. There can be no answer to that question until reporting of each case of blindness becomes mandatory. Until then, these indigent blind, who are estimated to comprise about one fourth of the total blind population, provide the only available records suitable for study. Despite these limitations, the data in this report are believed to be an advance toward the goal of comprehensive statistics on the causes of blindness in Florida.

Economic Blindness Defined

In this study, the term blindness means economic blindness, which in ophthalmic measurements is a central visual acuity of 20/200 or less in the better eye with correcting lenses, or a contraction of the peripheral field of vision to a widest diameter of not more than 20 degrees. The Standard Classification of Blindness (1957 Revision)* was used in this analysis. Though blindness may occur in each eye from different causes, the tables and charts included here relate specifically to causes responsible for placing the person studied in the state of economic blindness.

Incidence

The population of 3,141 blind persons to which this report relates equals the total population of Lafayette County and is larger than any known previous study in which the cause data have been taken from actual medical records. Hillsborough and Duval counties equally supplied information on the largest number of blind recipients; next came Dade, Polk, Pinellas and Escambia counties, in that order, with all six providing one third of the state's total number of 1947 to 1957 recorded blind recipients. In contrast, 27 counties—Baker, Bradford, Charlotte, Citrus, Clay, Collier, DeSoto, Flagler, Franklin, Gilchrist, Glades, Gulf, Hardee, Hendry, Hernando, Highlands, Jefferson, Lafayette, Liberty, Martin, Okeechobee, St. Lucie, Sarasota, Taylor, Union and Wakulla—contributed together only one per cent. Notwithstanding these differences, no one county had a predominating influence,

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

*Decennial U. S. population censuses from 1890 through 1920 and from the National Health Survey of 1935.

**A condition of eligibility for aid to the blind was based on the concept of economic blindness which is defined as loss of vision sufficient to cause inability to do effectively any kind of work, industrial or otherwise, in which sight is essential.

*This Classification was developed by the present Committee on Statistics of the Blind maintained jointly by the American Foundation for the Blind and the National Society for the Prevention of Blindness.

Table 1. — Classification by Site and Type of Affection of Blindness in Recipients of Blind Assistance*

Site and Type of Affection	Number	Per Cent	U. S. Average Federal Report[2] (Per Cent)	Case Incidence Average 1947-1954	Case Incidence Average 1955-1957
Total	3141	100			
Eyeball In General	782	24.8	22.8		
Glaucoma (excluding infantile)	479	15.2	10.5	38	64
Panophthalmitis, acute endophthalmitis	15				
Malignant myopia	88	2.8	3.4	9	3
Albinism	34				
Megalophthalmos (infantile glaucoma)	37			2.5	6
Aniridia	12				
Other structural anomalies specified	53				
Atrophic globe, phthisis bulbi	64		17.8		
Cornea	231	7.3		8.25	1.4
Interstitial keratitis	31				
Other keratitis	62				
Keratoconus	10				
Other affections of cornea specified	128				
Crystalline Lens	713	22.6	19.7	81.4	18.65
Cataract	708	22.5			
Dislocated lens	5				
Optic Nerve, Pathway	629				
Cortical Visual Centers	615	20.2	14.8		
Optic nerve atrophy		19.6			
Retrobulbar and intracranial lesions	14				
Uveal Tract	303	9.6			
Iridocyclitis and uveitis	63			26	3
Chorioretinitis	216	6.8			
Other affection of uveal tract specified	24				
Retina	382	12	12.8		
Retinopathy	79	2.5			
Retinopathy of prematurity	79	2.5		1.25	23
Detached retina	52				
Retinitis pigmentosa	77	2.4			
Macular degeneration	76	2.4		8.3	3.0
Other affections of retina specified	19				
Site Not Specified	101	3.2			
Ill-defined lesion specified	47	1.5			
No report on site or type	54	1.7			

*Includes records of 288 blind children from birth to age 16, receiving services from the Florida Council for the Blind.

though the Pinellas, Hillsborough, Polk counties' area claimed 17 per cent of all of the blind recipients in the state. Everywhere, more men than women were receiving blind assistance, the proportion of males being 73 per cent; 1,716, or 54 per cent, were white while 1,425, or 46 per cent, were Negro. Negroes appear to be overrepresented when judged by their 21 per cent proportion of the population of Florida.*

This study reveals that blindness is predominantly a handicap of older persons, though the median age of the entire group in this study was approximately 49 years, and for Negroes alone was 46 years. These figures reflect the absence of those blind in the economic levels above indigency, a group which presumably includes the senior citizens from other states who have emigrated to Florida because of congenial environmental conditions.

Of the total blind group, 77 per cent had less than 5/200 central visual acuity, while less than 2 per cent had restricted visual fields. These would be rated by the Committee of the Council on Industrial Health of the American Medical Association as having greater than 95 per cent loss of visual efficiency.

Causative Factors

The site and type of affection categories listed in table 1 and represented pictorially in chart 1 show that 782 cases of blindness involved the eyeball in general, with primary glaucoma accounting for two thirds of these, being present in 479 adults and in 37 children, or in 16 per cent of the total blind. The national average in 1940 was 10.5 per cent.[2] There were more males (283) with glaucoma than females (233), while Negroes appeared to be especially susceptible. Negroes blinded by glaucoma numbered 348, or 67 per cent of the glaucoma blind, with Negro women (191) outnumbering Negro men. This predominance of Negroes adds some weight to the theory advocated by Koeppe[3] that pigment deposition in the trabecular meshwork of the anterior chamber angle has a significant causal relationship to the increased intraocular pressure of glaucoma.

Structural anomalies and general degenerative changes, particularly developmental defects or malformations and atrophy or other breakdown of

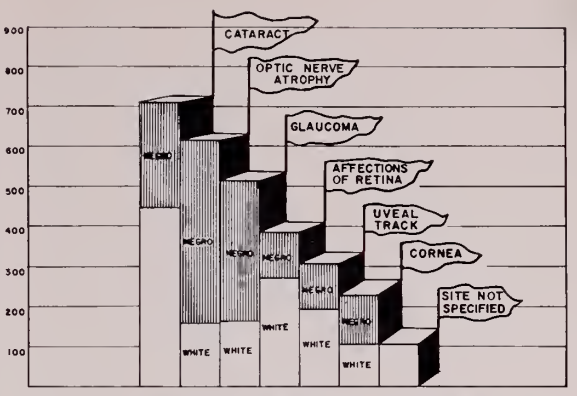


CHART I – CLASSIFICATION BY SITE AND TYPE OF AFFECTION OF BLINDNESS IN RECIPIENTS OF BLIND ASSISTANCE OR OF SERVICES FROM THE FLORIDA COUNCIL FOR THE BLIND.

the globe, were the site of blindness (table 1) in 9 per cent of the total. Faults of refraction and changes in a visually necessary structure accounted for 95, or for 3 per cent of all the blind. For all but seven of these, malignant myopia was the specified fault of refraction and was found more frequently (66) in the white recipient.

Cataract, or opacity of the crystalline lens, was found to be the most frequently reported eye defect causing blindness. It was reported for 708, or for 22.5 per cent of the total number. The 1940 national average[2] was 19.7 per cent There were numerous causative factors including heredity, trauma, infections, diabetes mellitus and those associated with the aging process. It was present in 327 males and in 381 females, in 448 whites and in 260 Negroes. Cataract was predominant in the 50 to 64 age group.

Affections of the cornea led to blindness in 231, or in 7.3 per cent of the total blind and were due to various types of keratitis or ulceration with consequent scarring and vascularization, none of which was sharply defined except for interstitial keratitis. These were reported for closely similar proportions of male and female recipients while Negroes were in greater number than whites (127 to 104). In the 31 cases of interstitial keratitis, Negroes outnumbered whites 4 to 1.

The optic nerve ranked second to the crystalline lens as a site of blindness while atrophy of this nerve was reported for 615 or almost 20 per cent of the blind total, compared to the 14.8 per cent 1940 average for the United States.[2] The most common etiologic factor was syphilis in 92, though for a larger proportion (347) the etiology was undetermined. Other factors were of genetic

*World Almanac (1958), published by the New York World-Telegram and Sun, indicated the population of Florida to be 2,771,305 at the time of the 1950 census, with 605,254 Negroes. The Florida Hand Book (1956), compiled by Allen Morris and published by the Peninsular Publishing Company, Tallahassee, estimated the population of Florida in 1956 to be 3,897,400 with 733,400 Negroes.

Table 2. — Classification of Etiology of Blindness in Recipients of Blind Assistance*

Etiology	Number		Per Cent	U. S. Average Federal Report[2] (Per Cent)	Case Incidence Average 1947-1954	1955-1957
Total		3141	100			
Infectious Diseases		488	15.5	24.6		
Prenatal syphilis	30					
Syphilis acquired after birth	129		5.8	7.7	16.5	8
Ophthalmia neonatorum	41		1.3	2.1	2.4	1.25
Other infection specified	288					
Trauma		224	7.1	10.1	22.2	15
Chemical causing burn	33					
Firearm using explosive	9					
Airgun	16					
Other explosive	12					
Sharp or pointed object	17					
Blow or fall	44					
Other agent specified	49					
Agent not specified	44					
Poisonings		86	2.7	0.5		
Methyl alcohol	3					
Quinine	2					
Excessive oxygen	79				1.5	23
Other poison specified	2					
Neoplasms		22	0.7	0.6		
Retinoblastoma	2					
Neoplasm, type not specified	20					
Disease**		266	8.7	4.8		
Vascular disease	110				11.5	6.12
Diabetes mellitus	76				6.75	7.00
Other disease specified**	36					
General disease not otherwise specified**	44					
Prenatal Influence**		166	5.2	9.5		
Genetic origin presumed	142				11.8	2.5
Prenatal influence not specified	24					
Etiology Undetermined or Not Specified		1889	60.1			
Unknown to science	1315		41.8	16.7-44.2		
No report on etiology	574		18.3	6.6-39.4		

*Includes reports on 288 blind children from birth to age 16 receiving services from the Florida Council for the Blind.

**Not elsewhere classified.

origin including heredity, 32 cases; infectious diseases other than syphilis, 27; trauma, 32; noninfectious diseases, 80; and poisons, 5. Atrophy of the optic nerve was reported much more frequently (353) for males than for females (262) while almost three times more Negroes (456) had atrophied optic nerves (whites 159). Optic nerve atrophy prevailed in the 18 to 49 year age group.

Affections of the anterior uveal region were responsible for 63 cases of blindness while the posterior uveal tract was the site for 240, or 7.6 per cent of the total blind. Anterior uveitis was divided almost equally between the sexes and the races, while affections of the posterior uvea involved 132 males and 108 females, 162 whites and 78 Negroes. These conditions were reported mainly in the age group under 17 years, although chorioretinitis ran the gamut from 18 to 64 years.

The retina as a site was recorded in 382 or 12 per cent of the recipients and was almost even with the national (12.8 per cent) average.[2] Retinitis or retinopathy accounted for 79 and macular degeneration for 76; an inherited defect, retinitis pigmentosa, limited the vision in 77 in this category. There were 52 cases of detachment of the retina and 79 of retrolental fibroplasia, also referred to as a retinopathy of prematurity. The causes of these retinal affections were varied and difficult or impossible to identify. For 44, the etiology could not be determined or was unspecified, while vascular diseases and diabetes mellitus were together responsible for 80 and trauma for 24. Prenatal influences did vital damage to an even 100 retinas, and the small remainder was divided among noninfectious and infectious diseases and causes unknown to science. Among all these there were 221 males and 161 females, though females dominated in the cases of retinopathy of diabetes 3 to 1, and 5 to 4 in those of macular degeneration. There were more whites (272) than Negroes (110). Macular degeneration and the retinopathies of vascular disease tended to lead in the older age groups, while in retrolental fibroplasia white babies outnumbered Negroes 4 to 1.

Table 2 and chart 2 present a classification by etiology. In the category "unknown to science" fall 1,315 cases for which a cause cannot be specified; they include cataract, glaucoma and myopia. The causal factor in 574 cases could not be determined because the blindness had been of such long duration that its origin was little remembered or because the globes were disorganized or had been removed surgically. When the etiology was known, infectious diseases had the highest incidence, being responsible for 488 or for 15.5 per cent of the blindness present in this segment of the blind population. Syphilis, prenatal or acquired after birth, was the greatest single cause of blindness, involving 159 in this group. Ophthalmia neonatorum, specific or otherwise, blinded 41. Other infectious diseases responsible for blindness were measles, meningitis (type not specified), scarlet fever, trachoma, tuberculosis, typhoid fever, rubella, and other infectious diseases not specified.

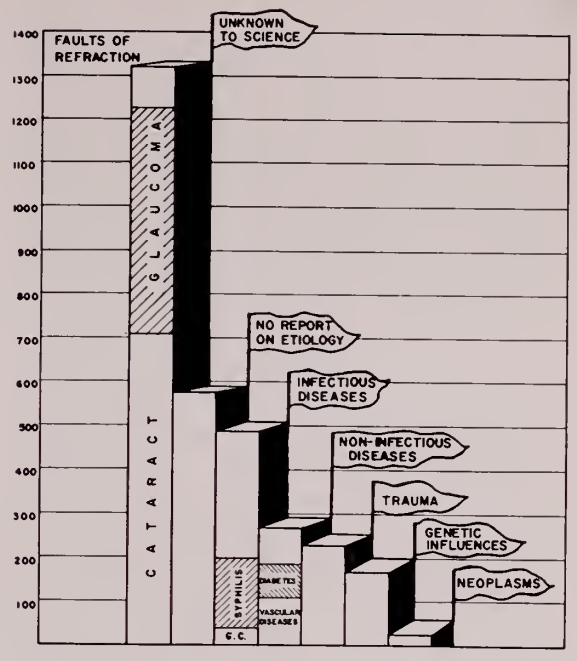


CHART 2 - CLASSIFICATION BY ETIOLOGY OF BLINDNESS IN RECIPIENTS OF BLIND ASSISTANCE OR OF SERVICES FROM THE FLORIDA COUNCIL FOR THE BLIND.

Diseases of genetic origin, excluding congenital syphilis, were presumed to be the cause of blindness in 166 and occurred in almost twice as many whites as in Negroes. Injuries, including chemical burns, accounted for blindness in 224 persons, with four fifths of the trauma associated not with industry but with sports activities, play with pointed objects or airguns, and malicious injuries. Several systemic diseases, mainly vascular disease, diabetes mellitus, diseases of the central nervous system, diseases of pregnancy, and nutritional deficiencies altogether accounted for 266 or 8.7 per cent of the total blind. Except for 79 cases due to excessive oxygen, poisonings appeared to be relatively of small importance. Loss of vision due to ocular neoplasms was only

reported in 22 because these lesions have a high rate of mortality.

It is noteworthy that the average incidence of site and causal factors during the period of 1947 to 1954 when compared to the more recent period from 1955 to 1957 inclusive, revealed a general decrease all along the line except in glaucoma, and in the retinopathy of prematurity, which last as of this moment should soon become nonexistent.

Summary

The causes of blindness in recipients of aid to the blind and in a group of blind children serviced by the Florida Council for the Blind from 1947 to 1957 have been classified from their eye examination records. The data obtained reveal that there is a predominance of eye disabilities associated with aging, and that glaucoma remains the greatest single, and increasing, source of adult blindness among all eye diseases in which visual restoration is not possible. Infectious diseases, trauma and poisonings, though preventable, still cause blindness in large numbers.

Conclusion

This analysis suggests directions to attack the specific causes of blindness which prevail in Florida. The problem of glaucoma is a challenge to provide early detection and adequate supervision. Competent ophthalmic advice and a good treatment program should materially reduce the too high incidence of blindness in a remedial ocular condition like cataract. Prevention of infectious diseases and adequate treatment of syphilis, diabetes mellitus and vascular disease are directions in blindness prophylaxis which beckon all physicians. All these plus continuing education of the public in regard to the hazards of airguns, bows and arrows, and pointed toys, eye safety programs in small industries as well as in large, and medical research especially in the field of genetics could reduce the incidence of blindness in Florida by two thirds. What medical effort could be more worthy?

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Discussion

DR. JOHN F. MCKENNA, South Miami: Dr. Rubin is to be congratulated on the energy he could bring to such a long and arduous task in addition to his very active private practice. He has, of course, anticipated the primary criticism of his study: that it represents not all of the citizens of Florida who are blind but approximately 25 per cent who have sought help because they are also indigent. Nevertheless, these are the best data available at the moment, and he is right in suggesting that this paper may be an introduction to possible future legislation that will require the registering of blindness as individual patients appear in offices for the first time. In these days of tax forms, compensation insurance forms, private insurance forms, Medicare, Blue Shield, reference letters and so on, one is reluctant to suggest such legislation, but I am sure ophthalmology as a whole will not be adverse because of the importance of the statistics which will be produced by such registration.

The data speak for themselves as regards age, sex and racial distribution, and need not be discussed further. Because this paper is being presented before the general assembly, and Dr. Rubin, in the limited time allotted, could only briefly touch on the significance of this study to generalists and others doing general physical examinations, I hope I am not presumptuous in enlarging somewhat on its significance to you here in this assembly meeting.

First of all, as you noted, cataracts were named as being the first most important cause of blindness. There is, however, a tremendous difference between blindness caused by cataract formation in an otherwise normal eye and blindness which is irreversible, such as is caused by optic atrophy and glaucoma. Many cataract patients will allow themselves to drift into reduced visual acuity, even to blindness as defined by Dr. Rubin, partly from inertia and partly because of fear of operation. You who practice general medicine can do your patients a real service by reassuring them and pointing out to them that the potentialities of successful surgery in qualified hands are very high indeed. This cause of blindness, therefore, should not remain as the first cause of blindness in Florida.

It should also be pointed out that there are many others of these causes of blindness which legitimately fall within the province of the generalist or physician doing general examinations. For instance, present evidence points clearly to the fact that macular degeneration is one of the many effects of arteriosclerosis. Early macular degeneration may respond to a low fat diet or lipotrophic substances, and in treating the patient for arteriosclerosis in general, you may well prevent this form of blindness.

Also, I should like to direct attention to the fact that this study lists those citizens of Florida who are blind in both eyes. If trauma should make up 7.1 per cent of these, it is obvious, I am sure, that this figure is misleading, because while cataracts and glaucoma and optic atrophy tend to be bilateral, trauma by itself tends to be unilateral, and the incidence of loss of vision in a first eye by trauma is much higher indeed. The loss of the second eye is, of course, a greater catastrophe than the loss of the first eye, but this does not alter the fact that the loss of the first eye, though not included in these statistics, is a tragedy that should be prevented in any way possible. High among the causes of trauma are air rifle accidents, and these are mostly in children. These can be prevented by banning the sale of air rifles in Florida. Such legislation undoubtedly will be introduced, and those of you who feel strongly about this may actively support it.

As Dr. Rubin has clearly pointed out, glaucoma is the greatest cause of irreversible blindness in Florida. This is

true also in practically all western countries. Elsewhere, with high incidence of such diseases as trachoma and gonorrheal keratitis, this is not true. In some western countries, the relative position of glaucoma as a cause of blindness is even greater. For instance, in a recent study in Iceland glaucoma was found to be the cause of blindness in 60 per cent of the blind population.

What has this to do with general medicine? In the past, nothing perhaps, but you should be warned that you are going to be propagandized very strongly in the future that the diagnosis of glaucoma is a general problem. As has been pointed out by the Public Health Service, as disclosed by certain screening tests, 2 per cent of the population over 40 years of age in this country has undiagnosed chronic glaucoma. There are about 60 million over that age. This means that if everyone over 40 were checked yearly, every ophthalmologist who is practicing today would have to check 8,000 persons or 16,000 eyes for glaucoma. Obviously, this is an impossibility. In Florida, for instance, if the population is four million and a third of these are over 40 and 2 per cent of them have undiagnosed glaucoma, then 27,000 adults in Florida have undiagnosed glaucoma. The generalist, therefore, must anticipate a continual growing pressure to add the diagnosis of glaucoma to his already overburdened routine.

How will you determine if the intraocular pressure is above normal? Not by fingers, of course, because this is inaccurate. The tonometers for measuring intraocular pressure used in ophthalmology are sensitive and expensive. It has, however, been pointed out by Dickinson (The Journal of the Florida Medical Association, September 1957, page 242) that a relatively inexpensive tonometer, which will register, yes or no, high or low, will soon be available, and it apparently will range in price only from $12 to $15. Dickinson also pointed out that in 1955 in Florida serologic examinations for syphilis, which are done at all hospitals as accepted routine, uncovered only 151 cases of syphilis per 100,000 patients. Yet there must be in that 100,000 segment of the population a considerably higher number, somewhere from one to two thousand persons, who have undiagnosed glaucoma.

Also, you must anticipate being asked to be aware of another form of glaucoma, that acute form which you have heard about as associated with dilating the pupil. The present popularity of belladonna compounds is extreme, and it must be emphasized that these compounds can and will dilate the pupil and in an eye that is predisposed to it by shallow anterior chambers, can and will precipitate acute glaucoma. Considerable effort is being made in medical schools now to teach senior students about these dangers. On those of you who are now in practice falls the burden to work it out for yourselves.

Dr. Rubin has presented a great deal of food for thought, not only to the ophthalmologist but also to the general physician. He has made a contribution of considerable stimulating value. I thank him for the opportunity to read and discuss his paper.

Dr. Shaler Richardson, Jacksonville: I have not had an opportunity to read Dr. Rubin's paper as I only received it this morning. I think it would be well to say that the ones who are receiving aid to the blind naturally constitute the basis on which statistics have been prepared. The mechanism of receiving aid to the blind is that the patient ordinarily is referred for examination by a social worker representing the Welfare Board or the Council for the Blind. The ophthalmologist makes the examination, and the form then is filled in and sent to the Welfare Board. Having served for some years as ophthalmologist to the Welfare Board, I have the chore of reviewing these applications and making the evaluation as to whether the patient is blind or not. This poses quite a problem because some of the reports are extremely sketchy and the pathologic terms are not clear. I am sure Dr. Rubin had considerable difficulty at times interpreting the pathologic classification that was put on the form.

Unfortunately, not only M.D.'s are allowed to make these classifications but optometrists also. The reason is that the federal funds supplement the state funds and the federal government insists that optometrists be given an opportunity to make these examinations. In our state, however, only a small percentage of them have been made by optometrists and mostly in the areas where it is difficult to get patients to an ophthalmologist. Naturally, in reviewing the reports sent in by optometrists the pathologic interpretation is sometimes not clear to me, and I have the opportunity of asking that the applicant be referred to an ophthalmologist for further evaluation.

I was interested in the districts which had the greatest number of blind—that is, on blind rolls, receiving blind aid from the Welfare Board. As I remember the diagram, they were the Duval County, Escambia County, Hillsborough County and Dade County areas. This distribution can probably be correctly interpreted on the ground that the social workers for the Council for the Blind and for the Welfare Board are probably more active in those areas. In the sparsely populated counties the social workers do not have the contact with the prospective recipients of aid to the blind. The cooperation of the Florida Council for the Blind and the Welfare Board is a most important factor in taking care of these people. For instance, if patients come in with cataract, many times they are referred to the Welfare Board and then to the Council for the Blind which in its turn arranges for the operation to be performed, thereby in most instances relieving the state from paying the blind pension.

I think the figure on the injuries from air guns is fallacious. As Dr. McKenna said, it is only when both eyes are injured that patients with these injuries are listed as being blind from an airgun accident. I know that in our office I recently reviewed the records, and within a period of one year we had 12 injuries from an airgun.

I want to congratulate Dr. Rubin for his monumental work in compiling these statistics.

Dr. Rubin, closing: One of the nice things about living in the South is that everyone is so kind. I appreciate the politeness of Dr. McKenna and Dr. Richardson in their consideration of my modest paper.

It is true that the paper is an analysis of persons on a level of indigency, but it is the only source available until it becomes mandatory by state law that nurses and doctors and social and health agencies are compelled to report all blindness.

I should like to say, too, that indigency does promote blindness by denying proper sanitation, perhaps food, diet and medical care, but blindness also creates indigency. In most instances I think it is probable that the male blind were at one time self-supporting and became indigent because of their handicap.

It is also true that the airgun statistics may not be altogether revealing, but we deliberately chose to analyze these cases not by eyes but by the condition that made the person economically blind. These persons that we have listed were unfortunate in having their better eye destroyed by trauma.

In regard to the interpretation of records, it was difficult. That is why our analysis covered the period from 1947 to 1957, even though the program was initiated in 1937, because in the first 10 years particularly, the records were not satisfactory. Even then, the records were not always adequate. It is true that there were diagnoses by optometrists, and it really was amusing if not tragic to see the type of diagnoses they made, especially when they were confronted later with a diagnosis by an ophthalmologist. In two instances in particular, there were cases of glaucoma which would not have been recognized.

A Re-Evaluation of Breast Cancer And Its Management

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As long as the etiology of cancer of the breast remains unknown, surgeons will continue to have differences of opinion regarding its management. This being the case, cancer research alone can eventually provide us with the answer. Unfortunately, these differences, though they have narrowed somewhat, still remain at great variance. If we are to better the results of our present day treatment of cancer of the breast, it is necessary for every surgeon concerned with this problem to re-evaluate his end results from time to time. In my re-evaluation of this subject, the same basic statistical facts of the past were employed; in addition, present day factual information regarding cancer in general, plus more experience and wisdom, led me to a newer, truer and perhaps more effective conclusion.

It has always been puzzling to me to find such wide variations of opinion among men of note and experience as to what comprises the best plan of management for cancer of the breast. Why should opinions be different? After all, we are dealing with the same anatomy, the same disease and the same operative technics. Why then should one be able to say that extensive surgery is more effective than simple surgery? Why should one be prompted to say that in his experience x-radiation and simple surgery are more effective than radical surgery or super-radical surgery? The same good men are operating on the same pathologic entities, in the same human beings of identical age groups; why then in the presence of such similar basic considerations should there be such wide variations of opinion?

Apropos to these observations, I would like to relate an incident which I had the opportunity of witnessing recently. A panel of four well known surgeons was discussing the subject of cancer of the breast before a general medical audience. One surgeon, whose name I will not disclose, but who by his radical concept has become well known for his super-radical approach for carcinoma of the breast, stated that he removed the breast, the chest wall, the internal mammary artery with its contiguous lymph nodes and then carried his dissection into the mediastinum, removing all the anterior mediastinal nodes. This type of super-radical surgery, he stated, was in his opinion most likely to give the greatest number of cures.

Another surgeon of note sitting next to him advocated the opposite view. He recommended a simple mastectomy, perhaps followed by x-radiation as the best means of dealing with carcinoma of the breast. He stated that he did not utilize sterilization procedures because of the reflex increased hypophyseal stimulation that followed secondarily. He thought that radical surgery is "too late" surgery and stated that surgery could never encompass or include all carcinomatous extension. The third man on the panel advocated classical radical mastectomy, but hesitated to recommend super-radical mastectomy. He was of the opinion that sterility operations should be included in those instances in which mensis was still active. Still another surgeon on the panel was completely at odds with himself. He could not make up his mind which procedure was best. He equivocated, hesitated and postulated, but could not propound an acceptable therapeutic approach, even in his own mind.

To me, this represented a most serious situation indeed. How is it possible for four outstanding surgical specialists talking before a body of doctors — all of whom are willing, ready and able to accept their principles and teachings — to differ so widely with one another on the same subject? Either all of these men, together or individually, or in some combination hold the true answer, or perhaps none of them do. Since there is no accepted cure for carcinoma of the breast at present, we must continue to resort to those measures which we know work best in our hands. To veer off on some extreme tangent without preliminary careful evaluation can only prove harmful and set us back further.

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Influencing Factors in Comparative Incidence

We must be aware of the natural underlying differences that exist in man the world over. In this regard we refer to demography, which is the study of human communities throughout the world. Stewart, of the National Cancer Institute in Bethesda, Md., talking at the Second National Cancer Conference in 1952, in Ohio, made the following observations: The incidence of cancer of the uterus and cancer of the breast in America is approximately the same. There are 25 deaths per 100,000 population at the present time. In the United States, carcinoma of the uterus is 60 per cent more common in the Negroes, while carcinoma of the breast and ovaries is 60 per cent more common in the whites. In the South African Bantu, carcinoma of the cervix is seven times more frequent than carcinoma of the breast. In French West Africa, carcinoma of the breast is three times greater than carcinoma of the cervix. There is the same number of deaths in the Japanese female from carcinoma of the cervix; however, one-sixth of the number of deaths in the Japanese female is due to carcinoma of the breast.

In India, the Deccani Hindu is poor; he marries early and has many children. Fifty per cent of the carcinomas in the women of the Deccan arise in the cervix. In the Parsee woman, however, who belongs to the well-to-do class, and who marries late and has fewer children, 50 per cent of the carcinomas arise in the breast. It is also noteworthy that in England, the better classes have a higher percentage of cancer of the breast. There is, however, a somewhat reciprocal relationship between carcinoma of the breast and carcinoma of the cervix in married and single women; that is, in the single woman, carcinoma of the breast is more common. Childless married females over 40 years of age have a higher incidence of carcinoma of the breast.

So we see that there are definite influences in different parts of the world that exert themselves in bringing about earlier or later development of cancer of the breast. Some of these factors are the age of the individual, whether married or not, the number of children born, economic status, hereditary factors, racial factors, religious factors, social status, hormonal factors, nutritional factors and the specific geographic area. One readily recognizes why there must of necessity be wide variations the world over, but, more important, how seriously these variations can affect the accuracy of world statistics. If statistics are essentially honest, if they are carefully evaluated and presented so that everyone can understand how they were arrived at, no great differences of opinion can possibly result. Why then do there still remain so many serious statistical discrepancies that continue to influence unfavorably our management of cancer of the breast? The following examples may illustrate the underlying causes for our present day statistical discrepancies and diversions:

Misleading Statistics

One example is illustrated in a report by Meyer, of New York University, Bellevue Hospital. In 250 cases of carcinoma of the breast radical breast resection was employed. Thirty-four surgeons carried out these 250 procedures. A more scientific publication would have included the figures of one or several men of excellent surgical experience. To take 250 such cases and divide the number by 34 surgeons would represent 34 different technical abilities and 34 different ways of handling the disease; delicacy, carelessness, hurriedness, and completeness or incompleteness are important factors that we all know seriously alter postoperative morbidity, mortality, recurrence, metastasis and ultimately the survival figures.

In the past years I have observed many leading surgeons operate. Every time I watched a new surgeon work, I found that his technic involved distinct and variable deviations. Some deviations were commendable; others were not. Routinely recording the combined results of resident and so-called surgeons is to dilute unwittingly the excellent results and statistics obtained by expert surgical endeavors. It is a well known fact that technical abilities vary remarkably even among men of stature; certainly the differences in technical ability must be even greater among men of lesser stature, and most certainly between accomplished and nonaccomplished surgeons. This we know continues to affect seriously end results and statistical values. The mere fact that a surgeon stated that he performed a "radical" resection of the breast does not necessarily imply that he actually employed a "standard classical resection." It is possible, indeed, that he merely removed the breast and the pectoral muscles.

Words are not facts. Unfortunately, many loose and meaningless terms find their way into statistical literature and are so accepted in a literal

sense. This is a grave error and serious handicap. For example, the indiscriminate use of the word "cure" instead of "survival rate" is especially serious. We cannot routinely employ the word "cure" in a literal sense since some surgeons, in reporting their five year "cures," actually refer to a five year "survival" of the patient, regardless of whether or not the patient died the next day of generalized metastasis. There are those who report a five year "survival" period in patients that are alive and well at the end of five years, with no evidence of recurrence or metastasis. Unfortunately, these variations have proved to be a serious handicap in classifying cases on a purely statistical basis, more especially when one makes comparative studies of the merit of one procedure over another.

McWhirter, in publishing his highly optimistic statistics, included in his five year survivals cases with obvious evidence of recurrence. This places McWhirter's work in serious jeopardy, and his figures do not merit comparison with the figures from other clinics which have reference only to patients with lesions removed by extensive surgery and are without evidence of recurrence at the time of statistical evaluation. In fact, from a purely comparative standpoint, McWhirter's statistics become less favorable and more meaningless.

Another example of error in our present day published statistics has to do with recording the date of onset of symptoms and signs. Questions answered by the patient may or may not be accurate. What a patient may consider to be a lump of one month's duration, may well be a lump of six months' duration. One of my patients stated that the mass appeared only 10 days previously. When asked if she was in the habit of observing her breasts periodically, she replied, "No." How long then was the mass present? When a patient first discovers a lump in her breast, the time should be recorded as "date of recognition" and not as "date of onset."

My patient's statement of "date of onset" as 10 days would ordinarily be literally recorded and interpreted as such statistically. Since at surgery I found advanced carcinoma with involvement of axillary nodes, the statistics would further imply that spread to the axilla occurred within 10 days of onset. It would then follow that this particular carcinoma was a rapidly growing one, whereas in reality its growth and axillary extension may have required several months. A routine self examination by the patient might have discovered this growth earlier while it was still confined to the breast. Here again it must be emphasized that when a woman first recognizes a lump in her breast, it must be considered a relatively late finding unless she was in the habit of carefully observing and palpating her breasts periodically.

The employment of various postoperative supplemental treatments in cases of mastectomy unfortunately is not always mentioned in published statistics. This omission seriously jeopardizes the comparative value of what surgery alone can accomplish. If McWhirter's recommended treatment is to be considered fairly, it should be evaluated for what curative effects his surgery and x-ray alone can accomplish without the addition of tagged-on supplemental treatments. For example, McWhirter's statistics include cases in which castration was performed and cases in which androgenic and estrogenic therapy was administered, while other surgeons and clinics have reported cases in which treatment was by surgery alone, with or without benefit of x-ray therapy. Until all of these "bugs" in our statistical reporting are corrected, until all "variations" that complicate statistical studies are recognized and corrected, nothing of real value can be attained by comparative studies.

In American clinics, statistics continue to show that more extensive surgery (or classical radical mastectomy) in carcinoma of the breast on more carefully selected patients gives the most superior results. The opponents of this method of treatment say, "Certainly, with the selection of better cases we should have better results." While this is true indeed, still it would be absolute folly and poor judgment in neglected and far advanced cases with evidence of distant metastasis to subject the patient to extensive curative surgery. All that surgery can possibly offer in such cases is dissemination of the carcinoma cells and/or enhancement of their rate of growth. In my opinion, therefore, it is absolutely justifiable and good sound surgical judgment to select only those cases for curative surgical extirpation that lend themselves to the best possible results obtainable. By employing classical radical surgery in cases of Grade III and Grade IV of Portmann's Classification, one can only hasten the spread of cancer, shorten the life span of the patient and jeopardize the position of surgery in the treatment of carcinoma of the breast.

Why should good and useful surgery be discredited by the poor selection of "too late" cases for radical surgical therapy? It is as unjustifiable as taking a 100 per cent medical problem and treating it 100 per cent surgically. If no surgical indication exists, no surgery should be performed. I believe that statistical studies of today are distorted and confusing and that reports such as McWhirter's have been seriously misleading since they have given inept, careless and hurried surgeons the chance to latch onto something that they can easily perform and promote against the more extensive, more deliberate and more favorable surgical procedure.

It should be our goal as physicians to hope to discover all premalignant and malignant lesions of the breast as early as possible, so that they may be more ideally classified as Grade I, and no more than Grade II, by Portmann's Classification. The "time interval" between discovery of the lump and the patient being seen for the first time should remain under three months—and preferably only one month. This is a goal to which not only the alert patients must aspire, but the physicians and surgeons as well. We must make every endeavor to bring the women in earlier for diagnosis; we must continue to bend every effort to indoctrinate the physician to refer his cases to the surgeon earlier and not to procrastinate with his patient for weeks or months before referring her. Shimkin and his associates, in 1952, commented that if patients delayed one month or less before coming in for treatment, an over-all five year survival rate of 60 per cent could be attained. This 60 per cent refers to the over-all percentage, which would be a 20 per cent increase over the present day statistics and a 40 per cent increase over the existing 20 per cent five year survival figure for all untreated cancers of the breast. In the absence of any real cure for cancer of the breast at the present time, we must continue to work towards this goal.

To date, cancer has been oversold to the lay public, and it is essential that the doctor too be oversold to the same limits as his patient. Under such a program there will be less possible delay between the time the patient first discovers the lump and the time she consults her physician and ultimately the surgeon. Most important of all, there must never be a delay from the time the surgeon sees the patient's lump to the date of the surgery. These factors alone can vastly improve our present day results without benefit of any new advance in the field of cancer therapeutics.

Significant Determining Factors

Though the time of onset or duration of cancer of the breast is still a significant factor, alone it is only partially important. Actually, we know that a carcinoma can be present in the breast for months or years, yet remain asymptomatic and localized until accidently recognized. I am aware of lesions of the breast that are recognized rather early, yet local invasion and early systemic metastasis have already rendered the disease beyond the scope and hope of surgery. Though time does in part, therefore, determine the degree and extent of the spread of cancer, it cannot in itself be considered the singular determining factor.

A far more significant factor would be whether or not the lesion at the time of evaluation is confined to the breast alone. DeLand, of the Massachusetts General Hospital in Boston, stated that before three months it is possible to see the highest percentage of cases of cancer of the breast without axillary involvement. After three months there is an ever increasing rise in the percentage of axillary involvement. These observations tend to substantiate that most lesions of the breast begin locally in the breast and usually permeate along the lymphatic channels to the lymph glands on the homolateral side. I am not unaware of the many other ways by which carcinoma cells may propagate themselves through tissue and capillary walls and disperse themselves throughout the venous channels; neither am I unaware of the embolic phenomenon of carcinoma cells occurring within the network of lymphatic channels and glands.

Stockholm surgeons have studied the blood from veins draining cancers of the colon, stomach, breast and lung. Specimens of the blood from these veins during surgery showed cancer cells in 59 per cent of 107 cases. Fisher and Turnball found cancer cells in the blood, while Engell found cancer cells in blood drawn from the cubital veins of patients with cancer. Cancer cells are appearing with increased frequency in bone marrow material aspirated from the sternum for biopsy. Engell did not mention finding cancer cells in the blood of patients having Grade I cancer (Broder's Classification), but found them in 35 per cent in Grade II, 78 per cent in Grade III and 100 per cent in Grade IV. It is note-

worthy that this author noticed no correlation between the presence of the cancer cells in the blood and the survival of patients. This fact would lead one to believe that the fate of the patient with cancer is determined less by whether cancer cells have entered the blood stream than by the resistance of the host, transplantability of the cancer cells and their biologic behavior. Also, according to this concept, early and wide excision of a highly malignant cancer cannot be accepted as a prevention against systemic spread.

This school of thought believes it is entirely possible that by the time the primary cancer is recognized clinically, the development of a generalized process is largely precluded. It also holds that the patient's survival is not dependent so much on whether the tumor was removed early as upon the transplantability of the tumor cells and the resistance of the host to these malignant cells. McNealy, speaking before the Second National Cancer Conference in 1952, in Cincinnati, Ohio, epitomized his life-long experience with cancer of the breast by stating the following: "The anticipated life expectancy of the patient is definitely a question of the cellular activity rather than the question of what type of operation is recommended by the surgeon." There are those who believe that removal of primary tumors can no more deter these cancers from spreading to distant organs than the excision of a chancre or gumma would cure or prevent the systemic spread of syphilis. It is possible that even after distant spread the malignant cells may die in transit, fail to transplant themselves successfully, or even after successful transplantation remain latent in sites for a varying length of time, only to resume growing at some later period.

A third belief of this school is that whatever does occur, it is ultimately dependent upon the resistance of the host and the transplantability and biologic behavior of the cells. It is a well known fact that a patient having cancer can live with unremoved positive nodal metastasis for as long as five or 10 years. Here then is a feature of cancer that can be explained either as some peculiar cellular latency (intrinic or extrinic) or inhibition of cellular growth without destruction of cellular metabolism, this peculiar feature being in all likelihood dependent upon hormones, enzymes, intracellular (autonomous) metabolism, host resistance and biologic predeterminism of the carcinoma.

Those who believe that from the moment cancer becomes perceptible, it is already a late systemic disease, further believe that the general and standard conception of cancer as beginning from a cell extending progressively both locally and distally should be abandoned and replaced by the concept of cancer as a general systemic disorder. It is possible that the generalized dissemination occurs before the time at which the patient perceives the first sign of cancer. It is probable that at many of the first consultations after the discovery of a lump in the breast, the stage of systemic dissemination has already occurred. Whatever the mechanism of carcinomatous diffusion or transport may be, whether via the blood stream or lymphatics, the patient is believed to react to this generalized cancer disorder and to the diffusion of malignant cells in an individual manner which eventually determines the pathogenetics of the disease and the ultimate fate of the patient. If this is true, then an antigen-antibody factor (host-resistance) must in all probability exist.

The ultimate fate of metastasizing carcinoma cells in transit through the blood stream or lymph is unpredictable. They may die in transit or at the site of destination, or the host resistance may be great enough to inhibit their growth or completely destroy them. Perhaps someday we will come to recognize that undue manipulation of a carcinomatous lesion can disseminate cells into the circulation or lymphatics. Here, too, is another example of the undesirableness of prolonged surgery. Short, sharp, good and complete surgery will require less manipulation and therefore result in less possible "squeezing" of malignant cells into the general circulation.

Since malignant cells floating in the circulation may land in various places for attachment and growth, it may be a good idea to destroy them in transit with some form of chemotherapy that will lower or destroy their metabolic activity or increase host resistance to them. A chemotherapeutic substance may someday be available that will effectively interfere with the nourishment of cancer cells at a time when they are floating freely in the bloodstream and need nutriment most; it may even exert a "cancerocidal" effect on the metabolism of the cells when they are closest to dying in transit. The chemotherapeutic substance which would interfere with the cellular metabolism of distantly metastasizing cells or metastasized cells would be a distinct advantage

to the enhancement of what surgery can already accomplish in the treatment of carcinoma of the breast. Finding a chemotherapeutic or "cancerocidal" substance that will sensitize or destroy malignant cells so that an enhanced effect may be obtained from present day surgery and/or x-radiation would be a definite milestone in the therapeusis of carcinoma.

On the basis of such new concepts of host resistance to carcinoma and antigen-antibody response, and in view of the reported differences of opinion on treatment of carcinoma of the breast, it is essential that we pause awhile and re-evaluate our present thinking on the subject of this disease. We must not be guilty of hastily dropping well known and proved methods of treatment in order to adopt rediscovered old practices; nor must we be too overzealous in carrying out new practices which, to date, have no justification or proved merit.

Objectives

One of my objectives in this paper is to encourage the continued use of surgical methods that have been universally employed for many years with proved results. Another objective is to promote the recognition of universally accepted methods of clinical and pathologic classification and diagnosis so that there can be no equivocation as to the best plan of management for the patient with carcinoma of the breast. A third objective is to awaken the interest of physicians to act immediately and without procrastination so that their patients with diagnosed lumps in their breasts will be brought to surgery at the earliest possible moment. Still another objective is to propose a practical therapeutic program based upon Portmann's clinical and pathologic classification of diseases of the breast, a plan which, if adopted, would lead to more accurate statistical reporting and, in turn, to honest and scientific comparative evaluations.

Survival Rates

Harrington, of the Mayo Clinic, speaking on radical mastectomy, was able to give some figures which reflected the progress of surgical treatment of carcinoma of the breast at the Mayo Clinic from 1910 to 1940, a period of 30 years. He was able to demonstrate that carcinoma with evident metastasis, when treated by radical resection, improved the five year survival rate from 23 per cent to 39 per cent. When radical resection was performed for carcinoma of the breast without axillary metastasis, the figures rose from 62 per cent to 85 per cent. There can be no question that these figures indicate what new and improved technics have accomplished in the past 30 years. In pursuing his statistical studies further, Harrington found that the 10 year survival rate for carcinoma of the breast without axillary involvement was 61 per cent, while in those cases with axillary metastasis, the 10 year survival rate fell to 18 per cent. In evaluating the 15 year survival rate, Harrington found that 48 per cent of the patients were alive without evidence of the disease in those cases in which no axillary involvement was present, and 12 per cent when axillary involvement was present. His 20 year survival statistics were 36 per cent in those instances in which no metastasis to the axilla existed, and 7.5 per cent when axillary involvement existed.

Not only Harrington's statistics, but the majority of all well known surgeons and clinics indicate that the survival period is greater in those instances in which axillary involvement has not yet taken place. The survival ratio comparing the 5, 10, 15 and 20 year survival periods with axillary and without axillary involvement is listed below:

Survival Ratio—of cases without axillary involvement as compared to those cases with axillary involvement:

In the 5 year group	2:1
In the 10 year group	3:1
In the 15 year group	4:1
In the 20 year group	5:1

The ratio of survival through the years continues to indicate that a lesion found in the breast without axillary metastasis can possibly be cured, and that it is imperative we deal with carcinoma of the breast at the earliest possible moment after its discovery, preferably before three months and if possible within one month. These favorable 5, 10, 15 and 20 year survivals weigh heavily against the theory of carcinoma of the breast originating as a systemic disease and strongly negate the belief that a lump discovered in the breast implies the existence of generalized metastasis.

At this point I want to re-emphasize that in cases classified as Portmann's Group III and Group IV the lesions are, in my opinion, "too late" lesions of the breast that should not be routinely treated with curative surgery. Group III and Group IV cases must not be allowed to dilute the excellent results obtained in the earlier

Grade I and Grade II cases in which extensive curative surgery has been employed.

It is perfectly well and proper, when listing a final analysis of present day accomplishment with surgical treatment of cancer of the breast, to mention specifically what the 5, 10, 15 and 20 year survival rates are with surgery based on the total number of such cases seen (early, late or "too late"). Such over-all statistics can only serve to point out the comparative excellent results attained with curative surgery on lesions considered early, as in Portmann's Group I and Group II cases. Such over-all figures should specifically point out the poor and disappointing results of curative radical and super-radical surgery upon lesions considered to be late or "too late" as in Portmann's Group III and Group IV cases. The present day statistics, based upon the total number of cases seen, strongly suggest the urgent need of being bettered by subjecting the patient to operation in more and more of Grade I and Grade II cases and less and less in Group III and Group IV cases.

Statistics based on the total number of cases seen should further decry that curative surgery is definitely contraindicated in most Group III and Group IV cases. It must be clearly shown how Group III and Group IV cases, when included in surgical statistics, distort the true picture and tend to discourage and impair the progress of our present educational cancer program. We must clearly demonstrate and persist in our teaching that carcinoma of the breast dealt with earlier gives the greatest hope for cure, and that being the case, we must continue to strive to discover more and more cases at the Group I and Group II level. I have never seen an early case of Group III or Group IV because it does not exist. Group III and Group IV cases must therefore be considered "too late" cases, and "too late" cases most often result from delay, ignorance, indifference or frank neglect. If the patient comes in early, if the cancer-conscious physician refers the patient early, and if the cancer-conscious surgeon operates early, we can improve our statistics dramatically without benefit of a single scientific advance beyond that which we now possess.

Horsley of the Medical College of Virginia has published some encouraging five year survival rates with cases in Portmann's Classification Group I and Group II. In Group I cases of carcinoma, he reported a 94 per cent five year survival period, and in his Group II and even some of Group III cases, he was able to demonstrate a 63 per cent five year survival rate. These figures are extremely encouraging and tend to stress the importance of classifying cases clinically before treating them; they also further exemplify the need for one man statistics. Every surgeon's statistics will demonstrate the fact that the earlier his breast cases are seen the less likely is he to find axillary involvement. It becomes self evident that, regardless of what research may possibly yield in the future, what new chemotherapeutic agents may be discovered for use against cancer, and how far radical surgery may be extended for cancer, breast lesions must come to the surgeon's attention for "excisional biopsy" and for "curative classical radical mastectomy" at the earliest possible moment, that moment being when the lesion is still confined to the breast alone. This of course means that more surgical biopsies and more radical mastectomies will be performed, but it also means that many lives will be prolonged and many more patients cured.

Evaluating Operative Technics

It was on the assumption that carcinoma usually begins as a local disease and extends into the contiguous lymphatics on its way to the regional lymph nodes of the immediate area that present day surgical technics of cancer of the breast were evolved. Unfortunately, because of the bizarre biologic behavior of the various types of carcinoma cells in their passage through the lymphatic channels, and the unpredictable direction of their path, there developed a tendency for some surgeons to speak of the lymphatic channels and lymph gland patterns of distribution as being frequently abnormal or anomalous. This idea is farthest from the truth. The fact is that whatever variations exist are primarily found in the biologic behavior of carcinoma cells and secondarily in the existing local pathology, local altered physiology and local anatomy. The lymphatic channels and lymph glands are usually patterned as any other anatomic system in the body; anyone claiming that the lymphatics are more often than not anomalous is most likely anomalous himself.

Too often the careless surgeon blames anomalous anatomy for his accidents. The fact that one man's nose is small and another man's nose is large does not necessarily imply that one man has an anomalous nose. A nose is a nose, with

definite olfactory functions regardless of size, shape or appearance. Lymphatic systems, too, are consistent in their anatomic distribution and function, and though they may vary frequently in size and extent from person to person as anatomy anywhere in the human body is prone to do, the usual and standard pattern does persist, and no surgeon can afford to deviate from this normal standard or "norm." It is all right to be aware of and recognize variations and to deal with them as they are found, but unless anomalies are first recognized as such, the standard operative procedure (S.O.P.) must be followed.

Though I favor a classical radical resection for Group I and Group II cases, I am fully aware that carcinoma of the breast, as carcinoma elsewhere, is not exclusively a local disease spreading locally into the regional lymphatics alone. I am well aware of the fact that carcinoma cells vary histologically, physiologically and pathologically, and depending upon just where they originate as in certain instances in which capillary vessels are in intimate relationship with them, the cells invade directly through the endothelial barrier and are swept away by the blood stream. I am also aware that extensive surgical resection on such lesions of the breast, regardless of how limited in extent they may appear to be, is of little or no influence upon the eventual fatal outcome.

To date, the superiority of extended radical resections or super-radical resections of the breast has not been demonstrated; however, what has been definitely demonstrated with supersurgery is its accompanying higher morbidity and mortality rates. Super-radical surgery incurs a 12 per cent mortality rate, or a death rate 12 times higher than the classical radical resection. Halstead, 50 years ago, found that radical breast surgery, when extended into the supraclavicular areas, hastened the patient to an earlier demise. Super-radical surgical procedures should be discouraged because of their mutilating effect and their violation of the principles of the behavior of cancer, and because of the fact that these procedures have no place in this specific type of disease. When a cancerous lesion is not actually confined locally to the breast, it is reasonable to assume that its cells have already metastasized to parts far remote where any form of surgery, regardless of its extent, is hopeless.

It is essential that clinically we break down carcinoma of the breast into its many stages of development so that it may be managed and reported upon more intelligently and uniformly. Unless these stages are differentiated, we shall continue to flounder on, erroneously evaluating one type of treatment against another without arriving anywhere. Until a better plan than

Portmann's Classification and Criteria of Incurability

GROUP I or STAGE I
- Skin—not involved
- Tumor—localized in breast and movable
- Metastases—none in axillary nodes or elsewhere

GROUP II or STAGE II
- Skin—not involved
- Tumor—localized in breast and movable
- Metastases—few axillary nodes involved, no metastases elsewhere

GROUP III or STAGE III
- Skin—edematous, brawny, red induration or inflammation not obviously due to infection, extension ulceration, multiple secondary nodules
- Tumor—diffusely infiltrating breast, fixation of tumor or breast to chest wall, edema of breast, secondary tumors
- Metastases—many axillary nodes involved or fixed. No clinical or roentgenologic evidences or remote metastases

GROUP IV or STAGE IV
- Skin—as in any other group or stage
- Tumor—as in any other group or stage
- Metastases—axillary and supraclavicular nodes extensively involved. Clinical or roentgenologic evidence of remote metastases.

Portmann's Classification can be evolved, we must continue to make use of it.

Only by instituting an acceptable universal classification of cancer of the breast will we eventually be able to evaluate cases uniformly and effectively and permit reliable comparative studies to be made that will lead us to sounder conclusions as to what constitutes the ideal treatment. When a lesion of the breast is diagnosed as belonging to Group I of Portmann's Classification, I believe extensive surgery within the realm of intelligence, sanity and good judgment, based upon surgical experience and a good knowledge of anatomy and more especially upon the behavior of cancer cells in general, should give us our most ideal results. According to present day statistics the world over, classical radical mastectomy for Group I and Group II cancer of the breast gives the best results with or without the use of x-ray postoperatively.

Though I believe that most Group II cases are beyond hope of cure by curative radical surgery, I know, too, that on a basis of reported errors, both pathologically and clinically, we can easily deprive certain Group I and Group II patients of the beneficial results attained by classical radical mastectomy. Since an approximate 30 per cent error exists in clinically diagnosing positively involved glands in the axilla, and a reported approximate 30 per cent error in correctly diagnosing the microscopic slide, and since a 40 per cent local recurrence accompanies simple mastectomy (a recurrence rate four times greater than with radical surgery), the surgeon would be depriving a substantial number of Class I and Class II patients of the benefits that may be derived from curative extensive surgery of the breast. The finding of cancer cells at the site of the excision after a simple mastectomy is often evaluated as "recurrence," when in reality it may represent tissue "left over" from inadequate and incomplete surgery.

For the reasons just stated, I strongly urge that we continue to offer the patient in all Group I and Group II cases the widest spectrum of possible benefit by employing classical radical mastectomy. On the basis that most patients in Group III and Group IV represent cases with local and systemic metastasis, I strongly urge that they not be subjected to surgery of any kind, unless there is a specific palliative need for local extirpation of a foul-smelling, infected or inflamed lesion at some later date. In such instances, simple "palliative" mastectomy may be recommended, but at no time should these cases be incorporated into the statistics of "curative" radical surgery for carcinoma of the breast.

Classical Radical Resection Challenged

In the past several years, classical radical resection of the breast has been seriously challenged. The challenges have necessitated a re-evaluation of our present day empiric management of carcinoma of the breast. They have not been without benefit since they have contributed to the better understanding and more critical evaluation of our present day management and end results of carcinoma of the breast. Every surgeon should, in view of these challenges, pause to re-evaluate the theories and principles upon which he bases the whole of his surgical judgment.

Much harm has already been done through McWhirter's advocation of simpler surgery since poorly trained and self-styled surgeons have quickly latched onto this so-called new teaching. Halsted, 50 years ago, warned his colleagues not to cast about for easy operations. Because radical resection of the breast leaves so much to be desired in Portmann's Group III and Group IV cases, it would be far better to discard our efforts with curative surgery in these two classes. Let us not, however, be so foolhardy as to discard the most effective surgical treatment known today for those cases in Group I and Group II.

One of the most serious of McWhirter's statements that unfortunately continues to be perpetuated is, "Where axillary glands are not involved it should be noted that the operative removal of these glands is unnecessary." Re-evaluations have been made by Saphir and Amromin of these "so-called" negative axillary glands removed at surgery, and when more careful serial sections were repeated, about 30 per cent revealed positive carcinomatous cell invasion. This would, if we were to follow along with McWhirter's teachings, deprive 30 per cent of the patients in our most favorable Portmann's Group I and Group II of having an extensive resection of the breast with the possibility of attaining a possible cure. The remaining 70 per cent of patients with positive nodes would be subjected to x-ray therapy without any knowledge whatsoever as to whether or not the particular cancer would respond to it. This is a serious misdirection of surgical teaching. In about 10 per cent of the cases, after

classical radical mastectomy for carcinoma of the breast with apparent clinical findings of enlarged axillary glands, pathologic studies failed to find any carcinomatous invasion. This group, too, according to McWhirter's teachings, would be deprived of the benefits of radical surgery.

From these reports we learn that about 30 per cent of Grade I cases are actually Grade II and that 10 per cent of Grade II cases are in reality Grade I. In about 10 per cent of the Grade II cases with no proved positive axillary nodes, McWhirter would have performed a simple mastectomy and unnecessarily irradiated the chest and axilla. Where a curative radical mastectomy would have done no harm, McWhirter's simple mastectomy in 30 per cent of diagnosed Grade I cases with positive axillary nodes would have deprived the patients of possible cure. If we must err, it must always be on the side that benefits the patient. To paraphrase McWhirter's statement, I would like to say, "Where axillary glands are not involved it should be noted that irradiation of these glands is unnecessary." According to McWhirter, about 70 per cent of his Grade I and 10 per cent of his Grade II cases would receive unnecessary x-radiation to the axilla and chest.

Darland, in reviewing 1,600 cases of cancer of the breast at the Pondville Cancer Hospital observed over a period of 16 years, stated that the clinical examiners incorrectly evaluated axillary nodes as positive in 10 per cent of the cases. In 20 per cent of the cases a positive diagnosis of carcinoma was made in the so-called uninvolved lymph glands after surgery; this 30 per cent error further emphasizes the necessity of carrying out thorough axillary dissections in all Class I and Class II cases. McWhirter generalized erroneously, "If more lives are to be saved by surgery, then the scope of the operation must be extended." By this he implied that radical surgery, if it is to be accepted as an effective treatment for cancer, should be able to attain good results with all types of cancer and in all types of patients regardless of the patient's condition or classification. His rationale on this point is wholly fallacious.

Why should McWhirter, or anyone for that matter, demand more of any specific treatment than it can offer? It would be like saying, "If more lives are to be saved by the use of penicillin, then the scope of the medication must be extended." Penicillin acts best only on a certain bacterial spectrum; Aureomycin finds its most effective action in another; Terramycin and Chloromycetin in another. If curative radical surgery will give us our best results only in Portmann's Group I and Group II cases—fine. Let us use it. If surgery fails to offer any benefits in Group III or Group IV cases, or if, in fact, it accentuates and disseminates the disease, then certainly let us not use it. That being the case, we must resort to therapeutic measures other than surgery for Group III and Group IV cases.

It is imperative then that we prevent this premature and unjustified trend away from radical surgery and interrupt the movement toward simplified surgery. Until unequivocal evidence to the contrary appears, every woman with a classified Portmann's Group I or Group II lesion should not be deprived of what is still considered the best operative procedure to date, namely, the classical radical resection. Anyone who subjects his patient to anything less should hold himself responsible for any result less favorable than our best published results for similar cases.

Proper Classification

It is my opinion that one cannot reduce human behavior or behavior of disease to any rigid formula or rule. To have a plan, however, for the proper classification of a complex disease so that various effective forms of therapies may be administered is indeed a wise approach. Though it may not be the best plan available, still it is a plan—and a fairly good plan is certainly better than no plan at all. So until something better comes along, we must proceed with a systematized plan of management for carcinoma of the breast and at the same time strive to better the results from each specific form of therapy.

It is often difficult to decide which cases of Portmann's Grade II should be managed by simple mastectomy and x-radiation, since one cannot accurately predict the degree of cellular activity of the malignant disease at the time of surgery, nor can one predict what the response would be of any given malignant lesion to x-radiation. Since one cannot prognosticate how any given lesion will respond to surgery or irradiation and since we know that certain lesions are not highly anaplastic, recognition of metastatic nodes in the axilla per se should not necessarily preclude inoperability. The benefit of doubt must always be given to the patient, and a classical radical mastectomy should preferably be performed.

In certain patients in Portmann's Group III and Group IV we may on occasion recommend palliative simple mastectomy followed by irradiation; however, in the majority of such instances we do not recommend surgery at all. Whenever a foul-smelling, fungating, ulcerative mass exists and the patient is unable to live with herself, a simple breast excision may be recommended. In the majority of Group III and Group IV cases, x-radiation therapy in the highest possible dosage is administered to all areas where carcinoma is known to extend.

Until something more conclusive, something more definitive, for the treatment of cancer of the breast is evolved, we must classify the different types and classes of carcinoma and the different clinical patterns of carcinoma into a workable plan such as originally suggested by Portmann so that we may more intelligently deal with these various lesions in their different stages and thereby more reliably evaluate and compare our results. It is important to remember that the different stages of breast disease, particularly Groups II, III and IV, do not represent different disease entities, but rather late variations of the same disease brought about by our failure to recognize and deal with the disease at the earliest possible moment. A more reliable comparative study can be made on a worldwide basis only when a more careful classification of disease of the breast and a more deliberate evaluation of the treatment for each specific grade of the disease are carried out locally.

Foote, of the Memorial Hospital in New York City, in dealing with the histologic classification of carcinoma of the breast, made some interesting observations. He described carcinoma of the breast as either "infiltrating" or "noninfiltrating," and he stated that 90 per cent or more of the carcinomas he had studied were of the infiltrating ductal type. He stated that the lobular carcinoma is uncommon and is present in over 2 per cent of the cases. This seems to corroborate in principle the findings of all important clinics, more especially those statistics published by Harrington of the Mayo Clinic in his review of over 8,000 cases. If it is true that 90 per cent of the carcinomas histologically are of the infiltrating variety, the over-all treatment must be that which is all inclusive; it cannot for the benefit of 2 or more per cent omit anything that would tend to give the patient anything short of the best chance for cure. This implies that a systematized curative surgical program must be routinely administered to all of the early-discovered lesions (Portmann's Grade I and Grade II); and a systematized conservative medical program routinely reserved for most of the "too late" lesions (Portmann's Grade III and Grade IV).

Supplemental Measures

Many reports have appeared in the recent literature in which more favorable end results in the treatment of carcinoma of the breast were attained by supplemental bilateral oophorectomy. The removal of estrogenic stimulation to the growth of malignant cells in carcinoma of the breast can be compared to the results that have been so favorably reported with castration of the male in carcinomas of the prostate. It is believed that in prostatic carcinoma, estrogenic substances tend to neutralize or counteract the effect of the androgenic secretion by the testicles. Castration of the male in carcinoma of the prostate has become routine in many clinics throughout the world. There are those who believe that after mastectomy, bilateral oophorectomy is unnecessary. They recommend medical neutralization of continued estrogenic stimulation and therefore administer testosterone propionate.

Prudente, of Sao Paulo, Brazil, employs a routine plan of postoperative administration of testosterone propionate (hormonal castration) in all of his cases of radical mastectomy. On the assumption that all carcinoma cells are not removed by surgery, and that remaining cells are still under the influence of the estrogenic stimulus, Prudente believes that he has bettered his statistics by 23 per cent with the routine postoperative use of male hormone. He also believes that he has attained an especially low recurrence figure following his mastectomies with routine postoperative androgenic treatment. Depending upon the age of the patient and grade of malignancy involved, he varies the dosage as follows: for Grade I and Grade II (Broder's Classification), 75 mg. weekly for four months and a four month rest period each year; for Grade III, 175 mg. weekly, and for Grade IV, 350 mg. weekly. The dosage is reduced whenever evidence of virilism, sexual excitability, increase in blood pressure and edema develops.

Surgical castration as a supplemental measure may be employed in those patients with carcinoma of the breast who are still in the premenopausal period. In those patients close to the climacteric

or as much as five years beyond that period, x-radiation castration may be employed. In those who refuse surgery or will not tolerate an abdominal surgical procedure too well, sterilization by irradiation is the preferred plan of treatment. Unfortunately, x-radiation castration is an incomplete method for eradicating total ovarian function. It has been shown on repeated occasion that bilateral oophorectomy is superior to irradiation castration. Ovaries removed from the body after having been irradiated for complete castration effect were shown to be only partially destroyed. Because bilateral oophorectomy is believed to remove completely the hormonal stimulating factor to carcinoma of the breast, we should, in every instance in which the indication exists, reduce that hazard by excision of the ovaries. It is my belief that surgical castration will do more lasting good in the earlier cases of Grade I and Grade II than in the "too late" cases of Grade III and Grade IV.

J. C. Lees, one of the outstanding challengers and antagonists of our basic pathogenetic assumptions on the growth, behavior and extension of cancer of the breast, as well as one of our most vociferous critics on basic considerations of what comprises "cure" and "curability" of cancer by surgical methods, after propounding his many criticisms of our present day cancer theories, cancer treatment and cancer results, concluded with the following:

1. "It is wise, unless the contrary is known, to remove diseased tissue.
2. "It is wise to give any treatment, which has been learned by direct clinical experience will probably improve the patient's condition, prolong life, relieve pain, restore function and prevent toxemia."

His final conclusion was, "From the above principles and with the information available, we can only go on to discover the best treatment using common sense and general experience of the way cancer behaves." From Lees' declarations we see how a statistician may go about propounding elaborate theories, demonstrating convincing figures and charts, and widely influencing current thinking and procedure, yet himself unable to offer any constructive recommendation, ultimately bowing to common sense, sound judgment, and most important of all, actual clinical experience.

Plan for More Systematized Program of Treatment

The following is a proposed plan for bringing more patients of "Medical" Class B (Portmann's Grade III and Grade IV) into the fold of "Curative Surgical" Class A (Portmann's Grade I and Grade II):

(See next page)

(A) PROPHYLACTIC TREATMENT
(LAY PROGRAM)
- (1) Education of public to the significance and advantages of early recognition of breast "lumps," painless or painful.
- (2) Teaching of monthly self examinations to all women starting at high school level.
- (3) Public education through physicians and all public health agencies concerning the importance of periodic self examination of the breast once monthly for a lifetime. Lectures, informal talks, and illustrative motion pictures will contribute effectively toward the goal of early detection of a "lump" in the breast. Existing public education programs must be stepped up.
- (4) Routine visit to the doctor twice yearly for complete physical examination.

(B) ACTIVE TREATMENT
(MEDICAL PROGRAM)
- (1) Early Surgical Consultation: Whenever the physician finds a "lump" in the breast, he should always, before instituting any form of conservative medical program, seek out competent surgical consultation first. This will in most instances reduce the duration of time from the onset (date of discovery) to the date of surgery (excisional biopsy), and effectively prevent Class A cases (Portmann's Stage I and Stage II) from ever becoming late Medical Class B cases (Portmann's Stage III and Stage IV).
- (2) Early Excisional Biopsy: Avoid aspiration biopsies. They are notoriously unreliable and may cause one to overlook an existing carcinoma.
- (3) Early Radical (Curative) Surgery on all "early" Class A cases (Portmann's Stage I and Stage II).

Class A—(Surgical Program)—50% of all cases

(1) Portmann's Stage I
   a. Comprises 20% of all breast cases seen.
   b. 85%—5 year survival.
      15% will not live 5 years.
   c. 30% error (Saphir-Amromin-Darland)
      Nonpalpable axillary glands found carinoma-positive after postoperative re-evaluation.

(2) Portmann's Stage II
   a. Comprises 30% of all breast cases seen.
   b. 45%—5 year survival.
      55% will not live 5 years.
   c. 10% error (Saphir-Amromin-Darland)
      Palpable axillary gland found carcinoma-negative after postoperative re-evaluation.
   d. 19% of carcinoma-involved axillary glands have low anaplasticity (Broder's Grade I and Grade II).
   e. 40% recurrence rate with simple mastectomy (4 times higher than with radical,) (Harrington).

Class B—(Conservative Medical Program)—50% of all cases

(3) Portmann's Stage III
   a. Comprises 30% of all breast cases seen.
   b. 15%—5 year survivals.
      85% will not live 5 years.
   c. 10%—improvement to 5 year survival by deep x-ray therapy with or without palliative surgery.

(4) Portmann's Stage IV
   a. Comprises 20% of all breast cases seen.
   b. 5% or less 5 year survivals.
      95% will not live 5 years.
   c. 10% improvement in 5 year survivals by deep x-ray therapy with or without palliative surgery.

Radical Surgical Program

Class A
Portmann's—Stage I; Stage II

(1) Classical radical breast resection
(2) Routine postoperative x-radiation
(3) Castration of premenopausal patients
(4) Preoperative and postoperative chemotherapy
   a. Cancerocidal agents
   b. Hormonal therapy

Conservative Medical Program

Class B
Portmann's—Stage III; Stage IV

(1) X-radiation (deep x-ray, radium, cobalt)
(2) Hormonal therapy
   a. Androgenic—before 65 years
   b. Estrogenic—after 65 years
(3) Castration in premenopausal patients
   a. Surgery (bilateral oophorectomy)
   b. X-ray (sterilization)
   c. Androgenic therapy
(4) When soft tissue and/or bony metastasis exists
   a. Adrenal suppression with Cortisone
   b. Bilateral adrenalectomy
   c. Hypophysectomy
(5) Foul-smelling, ulcerating, and infected lesion
   a. Simple mastectomy (palliative)

All cases are finally re-evaluated and re-classified in the light of postoperative findings and follow-up:

Classical Radical Resection of Breast Cancer

(1) Anatomic
(2) Pathologic
(3) Broder's Classification
(4) Portmann's Classification
(5) Estimate 5 year survival—
   (on basis of no evidence of any recurrence).

(4) Simple (Palliative) Mastectomy in all Class B "too late" cases (Portmann's Stage III and Stage IV). Deep x-ray therapy or chemotherapy may be employed.

(5) Cancerocidal Agents may be employed supplementally before and immediately after radical surgery of the breast to destroy all distally metastasizing cancer cells.

The following are the advantages of the foregoing proposed plan:

(1) A surgical or medical classification is established at once, and a practical program of treatment is instituted in the shortest possible time.

(2) After surgery, any discovered clinical errors in Stage I or Stage II cases requiring change or reversal of pathologic evaluation can be corrected at no disadvantage to the patient. No practical serious error can be made in regard to the treatment administered since the same surgical plan pertains to Grade I and Grade II cases. Prognosis becomes better and more reliable.

(3) Proper and orderly timing for routine employment of supplemental forms of therapy is considered in this plan, thereby making evaluations and comparative statistical studies more reliable.

(4) This plan will tend to reduce the wide difference of existing opinions regarding management of carcinoma of the breast. Factual findings and honest comparative studies will lead to greater unanimity of world opinion.

(5) General specific statistical advantages will be manifest even if all cancers of the breast are counted in the statistical evaluation since more Portmann's Stage I and Stage II cases will eventually come to early curative surgery while a lesser number of Portmann's Stage III and Stage IV deaths will result from "too late" and ineffective surgical intervention. The improved surgical results in Portmann's Stage I and Stage II cases and the diminished number of poor results in Stage III and Stage IV cases together will favorably enhance our ultimate overall surgical statistics.

Though certain disadvantages exist both in the Surgical (Class A) and Medical (Class B) cases, sound clinical judgment based on good clinical experience will eventually eliminate these difficulties. They are considered as follows:

I. Surgical (Class A)—(Portmann's Stage I and Stage II)
   1. A breast lesion may be too small to palpate or perhaps not be palpable at all; yet it may have spread to the axilla or distally metastasized.
   2. A breast lesion may have associated axillary nodal enlargement, yet pathologically no cancer cells can be found.
   3. A breast lesion may have metastasized to the axillary glands, yet be of such low anaplasticity (Broder's Grade I or Grade II) as to respond ideally to complete surgical extirpation.

II. Medical (Class B)—(Portmann's Stage III and Stage IV)
   1. A lesion of the breast may be adherent to the chest wall as a result of associated inflammation not due to actual carcinomatous invasion.
   2. Carcinoma metastasis to the axillary glands may possess such biologic behavior as to resist any form of irradiation or chemotherapy.

Summary

It appears that surgery alone has reached the limits of its effectiveness in carcinoma of the breast. It remains for some new supplemental factor, such as chemotherapy (cancerocidal drugs), hormones, radioactive isotopes, x-radiation, or some entirely new form of therapy to enhance materially our present day results. Until then we must consider more seriously a stepped-up educational program related to awareness of the relationship of lumps in the breast to carcinoma of the breast.

The surgeon, in order to err on the safe and correct side of good judgment for his patient's benefit must act on the assumption that the lesion is malignant. There are two types of diagnosis: (1) a clinical (or "practical") diagnosis made for the benefit of enabling one to administer immediate practical treatment, and (2) a diagnosis that is purely scientific (or "theoretical") and which is intended mainly for teaching purposes, retrospect (postmortem) analysis, argument, or research. The surgeon can ill afford to be anything but practical at all times.

One must bear in mind that palpable glands in the axilla do not always contain carcinoma cells. Similarly, it is important to remember that when axillary glands do contain carcinoma cells, the cells are not necessarily highly anaplastic. If they belong to Broder's Grade I or Grade II classification, they may possess low growth potential and be amenable to extensive surgical excision. In the 19 per cent of cases of such breast lesions, that is, those with clinical axillary involvement containing carcinoma cells of low Broder's rating, the patient should not be deprived of the benefits attainable with classical radical mastectomy.

Nonpalpable axillary glands, when re-evaluated postoperatively, were found to contain cancer cells in about 30 per cent of the cases.

Palpable axillary glands, when re-evaluated postoperatively, were found not to contain cancer cells in about 10 per cent of the cases.

A plan is presented urging a more systematized program of treatment (both surgically and medically) which, if generally adopted, can lead to a more reliable method of comparing and evaluating the results of the many prevailing plans of therapy in operation today.

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Management of Tension and Anxiety States With Hydroxyzine Hydrochloride

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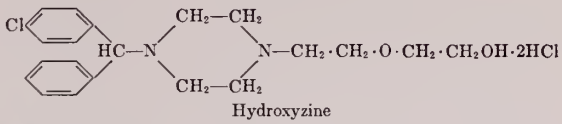
The need for a therapeutic substance that produces a calming effect on patients with emotional states of anxiety, tension, and agitation has led to the appearance of numerous ataractic preparations. Many practicing physicians will agree that 20 to 30 per cent of their patients suffer from psychosomatic afflictions, resulting from physical and emotional stress situations occurring in everyday life, or in association with true organic disease.

Anxiety states are often encountered in general practice. They may be manifested in a variety of ways, but usually are evident as heightened tension, or a feeling of apprehensive expectation. Situational factors which are dominant in the production of these symptoms should be changed, if possible. Psychotherapy is of primary importance in dealing with these problems, but with the advent of many new therapeutic agents, medical management has become less difficult. A complete and detailed history probably will determine some of the underlying causes and establish an early understanding between physician and patient. The recognition and treatment of these symptoms of mental stress may prevent the aggravation of pre-existent organic disease, such as gastrointestinal disorders,[1,2] cardiovascular disturbances,[3] asthma,[4] skin diseases[5] and many other conditions.

The purpose of this study is to evaluate hydroxyzine hydrochloride,* one of the newer and chemically different ataractic drugs. To date, in spite of extensive usage here and abroad, hydroxyzine has been free of reported toxicity in the therapeutic dosage range. At the outset of the study, nevertheless, I was apprehensive because of the serious toxic reactions encountered with a number of other tranquilizing drugs. Jaundice, leukopenia, depression and psychosis have been reported as side reactions of some of these drugs.

Chemistry and Pharmacology

Examination of the structural formula of hydroxyzine reveals an antihistamine-like formation.



Hydroxyzine

Modification of the basic structure at the piperazine group has given hydroxyzine special properties that distinguish it from similar preparations. Hydroxyzine hydrochloride is a crystalline solid that is readily soluble in water. Chemically, this compound is designated as 1-(p-chlorobenzhydryl)-4-[2-(2-hydroxyethoxy) ethyl] diethylenediamine hydrochloride. Ataractic action is the most prominent characteristic of hydroxyzine and forms the basis of its clinical use. Because it is water-soluble, the drug is quickly absorbed from the gastrointestinal tract, and therapeutic response usually is apparent within 15 to 30 minutes after ingestion. Its maximum effect occurs within one and one-half to two hours, and gradually subsides over a period of six to 20 hours.

Hydroxyzine has been employed clinically as a calming agent for the symptomatic treatment of a wide variety of emotional or mental disorders characterized by anxiety, tension, and agitation. It appears that it has been used more in the treatment of neuroses than of psychoses.[6] Its therapeutic effect on psychotic patients, however, is being enthusiastically investigated. Chemically, hydroxyzine is a close relative of meclizine (Bonamine) and has shown promise in Europe as a less toxic substitute for chlorpromazine.[7] American investigators have found that the toxicity of the preparation is eminently low. Drowsiness may occur shortly after ingestion just as with other ataraxics, but is usually transient. This effect, as distinguished from the calming action of the drug, seems to become less intense upon prolonged administration.

The acute and subacute toxicity of hydroxyzine has been investigated carefully in mice and rats.[8] Chronic toxicity studies in dogs have failed to show pathologic changes after prolonged therapy at doses well above the normal therapeutic range for humans. Rats given therapeutic doses of hydroxyzine became quiet within a short time, and their movements were observed to be

*Atarax, J. B. Roerig and Company (Division, Chas. Pfizer & Co., Inc.)

slower and steadier. As soon as they were disturbed from the outside, however, the animals instantaneously fled from the danger area without losing their customary agility and alertness.

Hydroxyzine was administered orally to four groups of two monkeys, each group receiving 25, 50, 100, and 200 mg/kg. of body weight respectively. An additional group of four monkeys received oral doses of 400 mg/kg. of body weight. When doses of 25 to 400 mg/kg. were administered, no hypnotic nor barbiturate-like effect on behavior of the animals was noted. Emesis was observed in one group receiving 100 mg/kg. and in all monkeys receiving 200 and 400 mg/kg. of oral hydroxyzine. Recovery was rapid and complete upon withdrawal of the drug.

Clinical Evaluation

European investigators who have administered hydroxyzine to a considerable number of patients in the past three years have found the preparation effective in a high percentage of subjects.

An interesting pediatric study was conducted by Bayart[9] in Belgium, who treated three series of patients with hydroxyzine. All children treated suffered from nervous conditions such as nocturnal nightmares, incontinence of urine, crying spasms and tics, and were otherwise emotionally disturbed. The dosage used in the first two series was 10 mg. of hydroxyzine three times a day, given by mouth for three months. The first series consisted of 70 children ranging in age from five to 12 years. The results showed a good response in 90 per cent of the patients after 10 to 12 days of treatment, while the remaining patients did not respond. In 78 per cent of the entire group, recovery was complete and the tics did not reappear, but in the remaining 22 per cent the tics recurred. To eliminate these relapses it was necessary to double the original dosage, thus giving 60 mg. daily in divided doses. This increase resulted in the disappearance of tics in 60 per cent of the relapsed cases; the others remained unchanged.

In the second series, comprising 56 patients ranging in age from seven to 12 years, the results were similar. With the cooperation of the teachers and parents of these emotionally disturbed children, beneficial results were usually achieved 10 to 15 days after the beginning of this therapy. The calming effect of hydroxyzine was remarkable and improved the emotional stability to a point where the children attained distinctly more regular and favorable scholastic results. In a third study, hydroxyzine was administered to hospitalized children who were distressed by the new environment, and longed for their parents. When the preparation was given, during the first four or five days of their stay, the children stopped crying, became definitely calmer, ate normally and slept quietly.

American and Mexican investigators experimenting with various dosage levels confirmed the European studies, and added valuable information with their own clinical data and impressions. Shalowitz,[10] for example, investigated hydroxyzine in 54 patients ranging in age from 65 to 90 years, with various degrees of senile anxiety. Good to excellent improvement was achieved in 51 of the 54 patients treated, and laboratory tests and electroencephalographic studies revealed no untoward effect on the liver, blood and nervous system after two months of therapy. When placebos were substituted for hydroxyzine, the clinical symptoms recurred. No side reactions, not even drowsiness, were reported. Particularly remarkable in this advanced age group was the absence of Parkinsonism. Farah[11] treated 96 patients aged two to 90 years, who suffered from neuroses often accompanied by somatic disease. He found the drug superior to similar preparations used previously. His results indicated that 82 patients had at least some relief of symptoms, while 14 patients responded inadequately. No manifestations of toxicity were observed during this study.

The clinical series reported here comprises 143 patients with commonly encountered neuroses such as anxiety states occurring in business executives, in laborers dissatisfied with their jobs, in patients experiencing emotional upheavals caused by disturbed family situations, and in those with associated organic disease. The ages of these patients ranged from three to 81 years. The preparation used consisted of coated tablets containing 10 mg. or 25 mg. of hydroxyzine hydrochloride.

For statistical purposes, the patients were classified according to diagnosis, and divided into five categories (table 2). There were 93 patients classified as psychoneurotic, a group which included those complaining of mental exhaustion, chronic fatigue, anxiety and excessive worry; 19 patients with hypochondriasis; 12 patients with various degrees of alcoholism; 10 patients with depression (senility, melancholia, borderline psychosis); and 11 women with menopausal disturb-

ances. The individual requirement of hydroxyzine was not related to age, sex, or body weight; it was found, however, that more intense symptoms usually required 25 or 50 mg. two to three times a day, while less severe conditions were controlled with 10 mg. two to four times a day. The length of treatment, from the shortest to the longest period, ranged from two weeks to 18 months.

Results

The diagnoses and the results of the study are summarized in tables 1 and 2. It appears, after analysis of the clinical data, that hydroxyzine is of considerable therapeutic value in the treatment of psychoneurosis. Anxiety, tension, and other symptoms of psychoneurosis, caused by circumstances described in the introductory part of the paper, were alleviated or considerably improved in 128 (89.5 per cent) of the 143 patients. The therapeutic benefits in these cases were observed in several ways; for example, some patients who were depressed when first seen became more sociable during treatment, and many with anxiety neuroses stated they had "immediate relief" from tension and were able to control their worrying with an occasional tablet of hydroxyzine.

Table 1

Disease	Number of Patients	Daily Oral Dosage Range in Milligrams
Psychoneurosis	93	30 - 150
Hypochondriasis	19	30 - 75
Alcoholism	12	30 - 150
Melancholias and depression states	10	30 - 100
Menopausal syndrome	11	40 - 100

Table 2

Patients	Excellent	Good	Poor
143	16 (11.2%)	112 (78.3%)	15 (10.5%)

Report of Cases

Case 1. — A housewife, 41 years of age, had a long history of numerous illnesses, which had been aggravated and complicated by periodic ingestion of excessive amounts of alcohol. The interview revealed further that she had the usual childhood diseases as well as diphtheria. Her menarche occurred at 14, and menstruation had never been regular. She had had dysmenorrhea for a long time and experienced only one pregnancy at the age of 26, which ended early in an abortion after an automobile accident. Subsequent to the accident, she had two ovarian operations and a complete hysterectomy at the age of 32. Sexual relationship with her husband had been disappointing since that time. When first seen, the patient appeared to be chronically ill; she was thin and nervous. The skin was of normal appearance. She had bilateral wheezes and rales posteriorly. There was pronounced scoliosis of the thoracic spine with limited motion. Rectal and pelvic examinations gave negative results.

The patient was referred to a psychiatrist, who stated that she was neurotic, suffered from acute alcoholism and was not ready for psychotherapy. Chlorpromazine therapy and meprobamate therapy were tried, in sequence, without success. A leukopenia had developed after two weeks of chlorpromazine therapy. Then, hydroxyzine, 25 mg. four times a day, was administered by mouth. The patient has been receiving hydroxyzine since, and has responded fairly satisfactorily. The leukocyte count returned to normal within one month, and the erythrocyte count, hematocrit reading, and sedimentation rate were all within normal limits.

Case 2. — A white bachelor, 28 years of age, complained of "black out" spells. There was a history of alcoholism, dating back to World War II, when he was a prisoner of war. Upon returning to the United States, he lived with his mother. His father was killed in the prison camp. The "black out" spells occurred after ingestion of excessive alcohol. The history revealed further that he had had several fractures of the extremities during childhood, and a fractured jaw which he sustained in prison camp when kicked by a Japanese soldier.

Physical examination showed a well developed and well nourished man in acute distress, with obvious post-alcoholic neurosis. The blood pressure, pulse rate, and weight were normal. Chest, heart, lungs, abdomen, and rectal examinations gave essentially negative results.

Examination of the blood showed a hemoglobin estimation of 13.2 Gm.; color index, 0.95; erythrocytes, 4.46 million; leukocytes, 7,200; and a normal differential count. The V.D.R.L. reaction was negative, and a urinalysis gave negative results. The patient was given Atarax, 25 mg. four times a day, and responded well for several weeks. There was no heavy drinking or anxiety. His mother reported recently that he had started drinking again, but between "sprees" he was able to control his anxiety and tension when taking Atarax as prescribed. He reported no side reactions. He has become a less severe alcoholic, and I consider this improvement due to the administration of hydroxyzine. The drug proved valuable, but, as one should expect, was not curative.

Case 3. — A white married woman, 43 years of age, presented herself with the complaints of nervousness and insomnia. She had recently been hospitalized for a large gangrenous slough on the left buttock, which appeared following an injection of chlorpromazine. This preparation was used during her last labor at the hospital. Treatment in the hospital included blood transfusion, antibiotics, debridement and general supportive care. Pronounced anxiety and tension developed after she was separated from her newborn baby boy for eight weeks after his birth. The history revealed no previous illnesses or operations.

Physical findings were weight, 116 pounds; blood pressure, 110 systolic and 78 diastolic; and pulse rate, 84. The patient was in good physical condition except for the lesion on the left buttock which was in the process of healing. The physical examination, including pelvic and rectal examinations, gave negative results. Laboratory studies, all giving negative results, included a roentgenogram of the chest, a Papanicolaou smear, a complete blood count and a urinalysis. The patient was given hydroxyzine, 10 mg. four times a day. She returned two weeks later and stated she felt like a "different woman;" her anxiety and tension had diminished considerably. Satisfied with the action of the preparation, she requested permission to let her husband use the drug also as he complained of malaise and easy fatigability. There were no side reactions in this study. The patient has been receiving hydroxyzine since April 1956. When recently seen at the office, she stated that she requires the preparation only occasionally, when she feels nervous and upset from her daily duties as a housewife. Her husband likewise has improved.

Case 4. — A married white man, aged 56 years, complained of pains in the chest. A severe chest cold in April 1956 was complicated by pleurisy and painful respiration. Roentgen studies suggested the possibility of bronchogenic carcinoma, which was confirmed by a

supraclavicular nodal biopsy. The patient was then informed just what the future held for him, since he had a metastatic bronchogenic malignant condition. He was given a course of 4,500 r to the chest wall over a period of 22 days as palliative treatment, but his condition became worse rapidly.

Since it was obvious that the condition was incurable and inoperable, his last days were made as comfortable as possible. He was given hydroxyzine, 25 mg. four times a day, in combination with increasing dosages of Demerol to suppress the pain. The patient was relatively relaxed and rational, considering his predicament, and in my opinion hydroxyzine was a contributory factor both for relaxation and synergistic action with narcotics, limiting the need for large doses of narcotics. Hydroxyzine could well be used in terminal carcinomatosis, and future investigations will probably elicit additional beneficent observations.

Summary

Hydroxyzine hydrochloride (Atarax) in daily oral doses ranging from 30 to 150 mg. was administered to patients with psychoneuroses with and without organic diseases, and to patients with hypochondriasis, alcoholism, melancholia, and menopausal syndrome. Of the 143 patients treated, 128 (89.5 per cent) had good to excellent responses, and 15 (10.49 per cent) a poor response. Drowsiness occurred in four patients (2.80 per cent), but subsided after several days of treatment when the proper dosage level was found. Two patients complained of excessive dreams and one of leg cramps. These symptoms were, no doubt, of psychologic nature and not due to hydroxyzine therapy.

The side effects in this study were minimal in comparison with those of the other tranquilizing drugs used in the past. Those encountered with hydroxyzine were transitory and were not of a serious nature.

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First Annual Conference

Of County Medical Society Presidents and Secretaries

December 14, 1958

Sellers Auditorium, Jacksonville

Sponsored by

Florida Medical Association

"We've Heard That Song Before"

Louis M. Orr, M.D.
ORLANDO

Ten days ago, I returned from the World Medical Association meeting in Copenhagen, where I was privileged to address the session on the worldwide problem of nuclear radiation. Two months ago, after having been named President-Elect of the American Medical Association, I addressed the Commonwealth Club of San Francisco on the serious national problem of medical quackery. Tonight, I am here to talk with you about still a third major problem confronting our profession and the American populace—proposed legislation within the framework of the Social Security system which could lead to national compulsory health insurance.

I wonder how many of you have heard about the proposals in the 85th Congress to provide Social Security beneficiaries with hospitalization and medical care benefits? Yes, I am referring to the Forand bill and other similar measures proposed or considered this year.

I wonder how many of you realize the danger of such bills to the private practice system of medicine and to the energetic and imaginative free enterprise medical programs for the retired and for all Americans? I wonder what you have done about this proposed legislation? Did you write to your Congressional representatives and senators? Did you explain to friends and neighbors the real significance of massive government intervention based on compulsory taxation (Social Security taxes) into the medical care field? More important, perhaps, I wonder what you plan to do within the next few months before the election of U. S. representatives and senators and before the convening of the 1959-1960 session of the Congress?

I can assure you it is somewhat discomforting to come here tonight to issue a call to arms, or at least to alert you to a serious problem facing our profession and the American people. Certainly, it would have been more pleasant, perhaps, if I could have talked about a less pressing matter. We in the medical profession, however, have become accustomed to challenges and to vital issues, and so I am sure you want to know what your American Medical Association has done, and is doing about proposals that would introduce health service benefits into the Old Age, Survivors and Disability Insurance structure.

As you may know, the Congress adjourned without taking action on the section of the Forand bill dealing with medical care benefits. We can, however, expect similar proposals to be reintroduced in the 86th Congress, and there is likely to be action on them during the next two years.

On June 27, 1958, two of your A.M.A representatives—Dr. Leonard Larsen, chairman of the Board of Trustees, and Dr. Frank H. Krusen of Rochester, Minn., winner of the A.M.A.'s Distinguished Service Award, testified against the Forand bill and similar measures before the Committee on Ways and Means. They presented some sound reasons why the A.M.A. and the physicians it represents are opposed to such legislation. For example, Dr. Larsen said:

"Today, you have before you proposals which would authorize service benefits in the form of hospitalization and surgical care for the retired and survivor beneficiaries under Title II of the Social Security Act. Such a proposal would mean a federally financed and federally controlled system of medical and hospital care, first for Social Security beneficiaries, subsequently for other groups and ultimately for everyone."

Dr. Krusen in his testimony commented on the actual effects of the Forand bill:

"H.R. 9467, if enacted, would authorize a federally subsidized and controlled system of hospital, surgical, nursing home and dental care, irrespective of need, for between 12 and 13 million eligible Social Security beneficiaries. This entire program would be under the direction and control of the Department of Health, Education, and Welfare and would be financed, in part, by an increase in Social Security taxes.

"Hospital care, including drugs, appliances and services customarily furnished by a hospital, such as bed and board, nursing care, laboratory services, and ambulance services would be available subject to administrative regulations, in those hospitals that enter into a written agreement with the administering agency. Eligible

President-Elect, American Medical Association.
Delivered before the DeSoto-Hardee-Highlands-Glades County Medical Society, Arcadia, Sept. 2, 1958.

nursing homes would be those where 'skilled nursing care' could be obtained, provided a written agreement was negotiated with the government. Physicians recognized by the bill as qualified to perform non-elective surgery would be limited to those certified by the American Board of Surgery or members of the American College of Surgeons. Hospitals, nursing homes and physicians would all be required to accept, in full payment for facilities and services, charges and fees established by the Secretary of the Department of Health, Education, and Welfare."

Undoubtedly, you have been saying to yourself: "We've heard that tune before. In fact, it sounds like a new version of the old Murray-Wagner-Dingell bill, with the exception that the current bill would start with a particular segment of the American people — namely, the retired."

I agree with you wholeheartedly. The tune is the same. It is the Murray-Wagner-Dingell bill once again, only with different words.

As in 1949, we believe today's proposed legislation is ill-advised and unnecessary. Certainly there are real medical care problems among the aged. You and I, and Doctors Larsen and Krusen, recognize this. We disagree, however, with the Forand bill proponents on the nature and extent of the problem, as well as the means of meeting it.

Personally, it is my opinion that medicine in general has been working overtime to increase the life span of Americans and that by its efforts has created first the growing aged population and second many of the problems that go with an older segment of the population. Just, however, as medicine and its allies—and this includes federal and state government aid when needed —have actually carried out the job of extending life, so we can now meet the problems that have arisen in this growing age group.

I do not for one moment believe that national compulsory health insurance is the only mechanism that can assure quality health care at a cost all the people can afford. Indeed, I believe such a mechanism is the last one that a free people should embrace.

I believe the introduction of health benefits into the OASDI structure is wrong and dangerous. I arrive at this conclusion for several reasons:

1. The cost would be unreasonably high. Proponents of the measure claim the cost in the first year would be roughly a billion dollars. The insurance industry's survey of probable first year costs puts the estimate at more than two billion dollars. When two surveys show a difference in estimates of 100 per cent, I believe there is good reason to suspect the lower figure.

Take a look at the estimates for the first year costs of nursing home care. The federal government's estimate is 12 million dollars; the insurance industry's is more than 40 times that amount—or 513 million dollars. Again, where there is such a wide difference in estimates, is there not good reason to question the low figure?

I believe with Dr. Larsen that a tremendous and unpredictable drain on the Social Security Trust Fund could seriously jeopardize the actuarial soundness of the entire program.

2. The physician-patient relationship as you and I have known it would change profoundly. The confidentiality and mutual respect that generally characterize the relationship between patients and their personal physicians could not continue under a nationalized program. Although the proponents claim that the relationship would not be affected, government regulations and conformance to them by patients and physicians are certain to hamper the traditional personal relationship of doctor and patient.

3. While the Forand bill limits health and medical care benefits to the retired and other beneficiaries of OASDI, it is inevitable that the programs would be expanded to include all persons under the OASDI system.

There is no reason why other segments of the population would not seek equal governmental privileges. In fact, it is almost certain that the paying members of the Social Security system would demand the same benefits as the non-paying, or retired, members would be receiving under a federal program.

4. Overutilization of hospital and medical facilities is a built-in feature of the proposed program. With personal and family financial responsibility eliminated, many aged persons would seek unnecessary hospital and medical care for trivial and imaginary illnesses and would become unduly concerned with their health. In other countries where similar legislation is in effect, there has been a staggering increase in the use of hospital facilities by the aged.

5. We could expect that the rapidly progressing voluntary health insurance industry—including the Blue Cross-Blue Shield and the private insurers—would be destroyed since voluntary

purchase of health insurance would gradually be replaced by national compulsory health insurance.

6. The federal government also would promulgate standards of health care and levels of compensation. In time, physicians, hospitals, nurses, and ancillary professional groups would be subject to extensive federal regulatory controls.

There are many other reasons for medicine's opposition to federally controlled health programs. You undoubtedly have some personal arguments you could add to the list.

Medicine's Alternative

While medicine certainly is determined to defeat schemes to add medical service benefits to the Social Security system, its aim also is to provide an alternative—a solution or series of solutions to the complex problem. I definitely believe that the combined efforts of individuals, families, communities, voluntary organizations, and agencies of the federal, state and local governments—within bounds—can provide for the health needs of the aged.

We already know that 40 per cent of the over 65 age group have some health insurance, and certainly the proportion of those insured will grow as the years go by. The idea of health insurance was not known to many of today's aged persons, but now almost everyone below the retirement age has had the opportunity to obtain health insurance protection and to know its value.

In addition, insurance companies now are seeking to create new types of coverage tailored to meet the needs of the aged ill. New approaches like preretirement financing of health insurance policies with paid-up status at 65; use of life insurance after 65 to pay for health care, and the application of deductibles and co-insurance to permit coverage of costly illnesses at a low premium rate are just a few of the ways in which health insurance can be spread among more of the aged.

Blue Cross currently is conducting experiments in covering nursing home and visiting nursing care for the aged. Blue Shield is experimenting with new programs for the aged in Kansas, Massachusetts, Delaware and other states.

The nursing home operators themselves are seeking to improve their standards and provide a quality service that will bridge the present gap between inexpensive but inadequate home care and adequate but overexpensive hospital care. The American Hospital Association, too, is active in the care of the aged, trying to contain rising costs.

All of us interested in a better program of health care of the aged realize the need for wider use of ambulatory or self service hospital care, skilled nursing home care, better use of practical nurses in or out of hospitals, home care programs, visiting nurses and improved housing for the aged, and we actively are planning for these.

Through the new Joint Council to improve the Health Care of the Aged our own American Medical Association is supporting a loan program by the federal government for hospitals and nursing homes and encouraging greater use of Hill-Burton funds for chronic disease units.

This month our Association is holding a planning conference on medical society action in the field of aging. The program will be devoted to finding ways in which all of us can promote the training of personnel and the development of facilities for the care of the aged . . . cooperate in developing community programs for the senior citizens . . . expand medical and socioeconomic research in reference to aging and the aged . . . and improve methods of financing health care for the aged.

In true medical fashion we are diagnosing the problem first and then proposing the necessary treatment. We intend to find the best methods to provide medical care for the aged, not political care.

Rehabilitation

We also are extremely interested in rehabilitating the aged, and we are not seeking merely the custodial care of these persons. Because the number of retired persons will increase by millions over the next few decades, we also are interested in reducing to a minimum the number of those who would be needy in their senior years.

Yes, the problem of the aged requires the application of rehabilitation and prevention as well as diagnosis and treatment.

Current Task

While it is true that our alternative to "political care" of the aged is diversified and perhaps quite complicated, we believe that there is no simple, blanket solution to the problem. Because there are many facets to medical care for the aged, the efforts of many segments of our society—in addition to medicine—will be required.

I believe our current task is twofold:

One, we must do everything possible to defeat proposed legislation calling for hospitalization and medical care benefits to Social Security beneficiaries. As A.M.A. President Dr. Gundersen says in his President's Page in the August issue of the Journal of the A.M.A.:

"If we as physicians are going to reverse the increasing federal control in health matters, we must act immediately. Within the law we must aid in the election of legislators who oppose national compulsory health insurance. If such men and women are not elected, then legislation may be passed during the 1959-60 session of Congress which would plunge the nation into such a national program from which there will be no hope of turning back."

So, I, too, urge you to contact the candidates for the U.S. House and Senate and to give them your views on political care health measures.

Second, we must exercise aggressive leadership at the local level to resolve the scores of problems facing our senior citizens. Through our efforts in local medical societies we can improve the health care of the aged and blaze a few new trails in the betterment of that care. By our local actions we can prove that it would be unwise and unnecessary for big government to extend its control and direction over American medicine and the health affairs of the American people.

Let none of us be fooled. The Forand bill and other similar proposed measures are merely variations on an old rejected theme—the Murray-Wagner-Dingell bill. The new words are no better for American medicine and the American people than the old ones of 10 years ago.

ABSTRACTS

Fate of Women with Positive Cervical Cytology. By James Henry Ferguson, M.D., and Harvey Lozman, M.D. South. M. J. 51:296-301 (March) 1958.

This paper is an account of the fate of 169 women who had cytologic studies of the cervix which resulted in a positive report. The longest follow-up period on these patients was about three years, and nine of the women were dead at the time of the study. Thirty-three of the patients in this series had invasive carcinoma of the cervix and approximately one-half, 16 women, had intraepithelial carcinoma. The experience of the authors did not support the placing of a lower age limit at which cervical cytologic examination can be useful, nor did it indicate that obstetric cases should be excluded from this type of study. One third of all their patients with positive cytologic smears were under 30 years of age. The average age of all women with positive cytologic smears was lower than that of women with intraepithelial carcinoma or invasive carcinoma.

Only six of the 169 women in this study were never pregnant. The antepartum and postpartum clinics are a rich source of positive smears, the authors observed, and they noted that in many instances the results of these tests become negative, apparently with the assistance of time and biopsies. In their experience, positive cervical smears disappeared spontaneously, others never reappeared after cone biopsy of the cervix, but all, they concluded, should be followed indefinitely.

Management of Nonpenetrating Thoracic Injuries. By DeWitt C. Daughtry, M.D. Am. Surgeon 23:462-474 (May) 1957.

In this present day of high speed automobiles, increasing air travel, mechanization of farms and a large number of people working with other machinery, thoracic injuries are responsible for a large percentage of accidental deaths. Approximately 25 per cent of automobile accident deaths are due to thoracic injury. The frequency of severe thoracic injuries and the immediate and subsequent complications encountered should, in the opinion of this author, so impress the physician that he will consider every chest injury as potentially fatal. The deranged physiology is often out of proportion to the apparent extent of trauma, he points out, and accident room management often determines the patient's subsequent course.

Prompt institution of the necessary emergency measures, control of pain, correction of paradoxical motion of the chest wall, maintenance of an adequate airway, relief of pneumothorax and careful observation for more unusual complications or associated injuries will greatly decrease morbidity and mortality rates. Multiple specialty consultations are often necessary. Extensive thoracic injuries in the heavy smoker, the aged, or the patient with poor respiratory reserve require especially detailed attention. General and specific therapeutic measures are discussed in some detail, and more unusual injuries or complications such as fracture of the trachea and torsion of the lung are mentioned. The author observes that well trained physicians of today should not continue to accept severe morbidity, long term invalidism and a mortality rate of approximately 10 per cent in patients with thoracic injuries admitted to the hospital.

Periventricular Calcification and Cytomegalic Inclusion Disease in Newborn Infant. By George Daurelle, M.D., George F. Smith, M.D., and William Riemer, M.D. J. A. M. A. 167:989-991 (June 21) 1958.

A case of advanced periventricular calcification in a newborn infant is reported for the purpose of directing attention to the unusual findings on the skull roentgenograms. The films disclosed calcium lining the walls of the lateral ventricles of the brain. Such a picture has been reported four times previously, all in infants with generalized cytomegalic inclusion disease. The patient in the case presented showed the characteristic cells of cytomegalic inclusion disease in the urine. The authors describe this case to suggest that this radiographic finding, when present, indicates a diagnosis of cytomegalic inclusion disease and may be pathognomonic of the disease.

Agranulocytosis Resulting from Methimazole (Tapazole): Report of Three Cases. By Maurice Rich, M.D., and Martin S. Belle, M.D. J. A. M. A. 167:573-575 (May 31) 1958.

Since the introduction of methimazole (1-methyl-2-mercaptoimidazole; Tapazole), in 1949, it has been utilized as a potent antithyroid drug and in recent years has almost completely replaced thiouracil and propylthiouracil in the medical treatment of hyperthyroidism. A number of toxic reactions, however, have been observed with the use of this agent. The occurrence of agranulocytosis following the administration of this drug constitutes a real hazard to life. It is the purpose of the authors in this paper to direct further attention to this possible dangerous toxic effect of methimazole by reporting three cases of agranulocytosis induced by this drug, one of which terminated fatally. They conclude that frequent performance of white blood cell counts is advisable during the administration of methimazole, although it is not certain that this measure will anticipate the possible production of agranulocytosis by this drug.

The General Practice of Pathology. By Gretchen V. Squires, M.D. South. M. J. 51:922-923 (July) 1958.

Dr. Squires thinks the time has come when pathologists must attempt to master all of the branches of clinical pathology plus pathologic anatomy, or they must delegate, in a satisfactory manner, well within the bounds of the ethical practice of pathology, those portions of their pathology duties which they themselves cannot master. This problem is rather easily solved in large institutions where "spheres of interest" can be filled by other pathologists within the same department. The problem child, however, remains as always the "one pathologist" hospital which includes a large segment of the profession. In her opinion there is a definite place, commensurate with his dignity and degree of training, for the nonmedical specialist within the framework of the well run pathology department. She points out the mistake of failing to give him, in particular the Ph.D. specialist in the paramedical field, the credit and financial remuneration his training and graduate degree deserve.

To meet the seemingly insurmountable problem of adequate income for such highly trained personnel to serve the small hospital Dr. Squires suggests a plan similar to the community blood bank program in which a group of small hospitals would work out a program with regard to special technical services. She also proposes another approach to the problem through liaison with nearby medical schools.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Paramedical Problems

In our present era of the increased application of technology to the practice of medicine, our professional field has, of necessity, become surrounded by an ever increasing number of rather spacious medical borderlands. The proper place and representation of these areas in the total picture of Medicine give rise to a number of basic problems of rather major importance, to which insufficient consideration has been given by our profession in the past. The time has come to scrutinize these problems and plan for the future.

Elemental in the approach to such a situation is a careful definition of terms and boundaries. Indeed, such careful definition, together with a concisely accurate statement of the problem, will do much toward providing us a satisfactory solution. Let us, if we are able, first draw a clear and broad line between the valuable, conscientious ancillary groups providing scientific care and information under the direction of qualified physicians and that large body of enterprising but unscrupulous and dishonest charlatans who are constantly preying on the fringe areas of medicine and exploiting those unfortunates whose judgment is weakened by illness and apprehension. And, second, let us clarify our own thinking to the extent that we can set down a table of organization delineating the proper relationship of the acceptable and valuable paramedical services to the profession of Medicine as a whole and to the guiding hand of the physician himself. Tackling such a problem, one becomes immediately aware of its hidden magnitude and the necessity for much sober and thoughtful reflection upon its past, present and future aspects.

A statement recently published by the Board of Trustees of the National Medical Foundation for Eye Care very thoughtfully and concisely outlines objectives which it seems to me are applicable to our entire profession. I quote:

1. "Medicine must re-establish its primacy, its over-all responsibility and authority, in the realm of medical care.

2. "Medicine should undertake to define the conditions under which any paramedical groups may or should be licensed. (Does the public interest require their licensure, or would licensure only lead to independent functioning which is not in the public interest?)

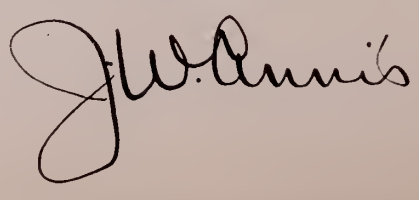
3. "In the interest of a better coordinated professional service, medicine should determine and define the need for each paramedical group, its functions, its educational standards, and the manner in which its members (whether licensed or unlicensed) are to be recognized and supervised.

4. "Medicine should assert the principle that every physician has the legal right to do anything for the patient that his medical care requires, and that he further has the right to delegate to any paramedical worker any technical procedure.

5. "Medicine should further assert the principle that whatever privileges may at any time be granted to limited practitioners or paramedical workers, whether by law or otherwise, such grant in no way circumscribes the physician's authority in that field and in no way restricts the practice of medicine by the physician.

6. "The medical profession as a whole should recognize the basic fact that whenever any paramedical group succeeds in establishing independent status in any area of professional medical practice, or in circumscribing or compromising the authority of the physician in any area of professional medical practice, the threat or the damage extends to all of medicine and should be of concern to the entire medical profession."

These statements merit our most careful consideration if we are to evolve a satisfactory architectural plan for the firm foundation upon which we can erect the huge, complicated and dignified structure which will house, in a proper and professional manner, all things medical.



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The Value of the Electrocardiogram

During the past year, a few pertinent articles and editorials appeared in medical journals warning physicians of the dangers of the promiscuous use of the electrocardiogram. The authors usually expressed the fear that much iatrogenic heart disease was caused by the injudicious use and improper interpretation of the electrocardiogram. No one can gainsay the validity of their thesis.

Yet, despite these warnings, more and more electrocardiographs are being sold and more tracings are being made than ever before. The average patient has come to regard the electrocardiogram as the equivalent of a cardiac consultation, and certainly no cardiac evaluation would be considered complete by most physicians without an electrocardiogram although the astute cardiologist recognizes that it is valueless in many cases.

Perhaps if physicians understood the whys and wherefores instead of the do's and don'ts, electrocardiography would assume its rightful place as a diagnostic aid of very limited value in most patients with heart disease.

As physicians, we constantly strive to establish new diagnoses to aid the sick, and in our quest for the cure of man's ills we are constantly devising new diagnostic tools and aids. At times. it appears that many simple diagnoses become lost in the morass of diagnostic tests used to establish them. Because of our indigenous laziness, we order diagnostic procedures hoping to obtain an answer in shorter time and with less mental perturbation than the time consumed by adequate evaluation of the problem and proper selection of diagnostic aids and confirmations.

Thus, when the technic of electrocardiography was rather difficult, few tracings were taken. Now that direct writing machines, which any child can properly operate, have become available at a most reasonable cost considering the financial return, it is easier to order an electrocardiogram than to take the time necessary for an adequate history and physical examination. Unfortunately, too, because of the great value Americans place on machines and gadgets and because of the physician's lack of the adequate nosogeny of cardiac disease, the electrocardiographic tracing is thus accepted as the diagnosis by the physician and the patient alike.

Physicians know, but few realize, that the electrocardiogram is merely a recording of the depolarization and repolarization of heart muscle fibers. It is this and nothing more. This tracing is altered by various extracardiac factors and too frequently by errors in technic. In our zeal to obtain all possible knowledge from the electrocardiogram, we have attempted to and have almost convinced ourselves that we could change basic physical laws. Despite the brilliant work of Wilson, Goldberger, Grant, and others, the total summation of electromotive forces recorded in one plane cannot be resolved into two or three planes and vice versa. The attempt of these and many other investigators to remove the interpretation of the electrocardiogram from an empiric to a scientific level has been of no avail. Postmortem pathologic correlations of electrocardiographic findings leave an aura of agnosticism surrounding the questioning mind. Recent studies of Prinzmetal's group would call for a re-evaluation of many basic tenets. Too many capable investigators have adopted an almost cabalistic approach to the electrocardiogram, and as a result, months of study on minimal gradient changes will undoubtedly prove just as important as how many angels can dance on the point of a needle.

Because it had been shown that acute myocardial infarction was often associated with electrocardiographic changes, the recent increase in coronary artery disease, with its resultant myocardial disease in the general population, has caused the electrocardiogram to become the diagnostic procedure sine qua non. So deeply has the electrocardiogram become associated with coronary artery disease that many physicians who should know better will diagnose coronary artery disease from a tracing and will not diagnose an acute myocardial infarction because of the lack of electrocardiographic findings even in the face of typical clinical findings.

Likewise, because of the association of the electrocardiogram with myocardial disease, various tests were devised in an attempt to diagnose coronary artery disease basing changes occurring in the electrocardiogram after exercise or anoxemia as evidence of disease. The very fact that the tests are not to be performed as screening procedures and not in the face of known coronary artery disease proves their worth.

What, then, is the value of the electrocardiogram? Certainly no one doubts its worth in the diagnosis of cardiac arrhythmias, which in some cases can only be established by its use. If an electrocardiographic tracing confirms a diagnosis of myocardial disease, it is most comforting to the physician. Since an electrocardiogram is merely the instantaneous summation of electrical impulses of a myriad of cardiac muscle fibers, it can never predict heart disease. Always when the tracing is at variance with the clinical diagnosis established by a careful diagnostic survey, man's brain which has made this diagnosis had best supercede the results of this diagnostic tool designed to ease the burden of man's brain but not to replace it. It is only in this way that the electrocardiogram will exhibit its true value of what it is and what it can do rather than what we hope it will do but never can.

"Long May Our Land Be Bright With Freedom's Holy Light"

Once again, November brings a very special national holiday. In keeping with American tradition, at the fruitful season of the waning year the nation perennially pauses to give thanks on high for its manifold blessings. "Thanksgiving Day," it has been aptly said, "is only our annual time for saying grace at the table of eternal goodness." It is sound psychology as well as good religion that we the people of the world's most fortunate nation express at this season our genuine appreciation of those forebears who, three centuries and more ago, celebrated the first Thanksgiving Day. It was their industry and courage that enabled them to hew from the virgin forest this great nation. To their steadfastness and faith we owe the ideals of liberty and justice that have become our treasured inheritance.

It is good that we turn from today's mad rush of worldly affairs to keep faith with our fathers in the spirit in which they established Thanksgiving Day. Gratitude for the abundance of our material and spiritual endowments, for the preservation of our way of life and for the beneficent influence of a steadfast religious faith on our destiny is wholesome in its effect upon the mind, the heart and the spirit of man.

Freedom is the priceless heritage Americans have long cherished. We take for granted our vaunted four freedoms—freedom of worship, freedom of speech, freedom from want and freedom from fear. A fifth freedom, about which we hear little, is equally important—freedom of choice. Certainly the philosophy of free choice touches on every phase of daily life, and the health of

the nation is no exception. This freedom has particular bearing on the medical profession for it is vital to the proper doctor-patient relationship.

Recent socialistic trends in the nation have sought to curtail this relationship and have nibbled away from this approach and that, directly and indirectly, until the profession has at last come to realize that the future quality of medical care may be at stake. If America's physicians are to continue to engage in the free practice of medicine and provide the highest quality of medical care in the world, they now have the opportunity to express their gratitude for past and present freedoms by standing firm against and alerting the public to the dangers of piecemeal curtailments leading down the road to socialized medicine. Dr. Louis M. Orr, President-Elect of the American Medical Association, emphasized these dangers in an address made recently before the Desoto - Hardee - Highlands - Glades County Medical Society. Entitled "We've Heard That Song Before," this speech is published in this issue of The Journal.

From first hand knowledge of Britain's bitter experience, Harold McMillan, Prime Minister of Great Britain, remarked, as quoted in the initial issue of The AMA News: "There is no difference between Socialism and Communism except this: Socialism is soft, Communism is hard; Socialism is pink, Communism is Red. Socialism gets you down bit by bit by a kind of anesthetic process. It might be called mercy killing. Communism just knocks you on the head." Through complacency and indifference, let us not be anesthetized into surrendering any of our precious heritage to the sinister forces that would destroy our freedom. As America gives thanks at this special season of the year, let every doctor, every patient, every citizen acknowledge and strive to measure up to his personal responsibility for keeping our land "bright with freedom's holy light," lest we all become victims of mass mercy killing.

Annual Conference Of County Medical Society Presidents and Secretaries

The Florida Medical Association is sponsoring the First Annual Conference of County Medical Society Presidents and Secretaries on December 14 at Sellers Auditorium in Jacksonville. The auditorium is located at 515 Lomax Street in the Riverside section of the city.

A.M.A. Clinical Meeting Minneapolis, Dec. 2-5, 1958

Early next month Minneapolis will be host to the A.M.A. Twelfth Clinical Meeting. Registration will begin at 8:30 a.m. on Tuesday, December 2. The meeting will close each evening at 5:30 p.m., and will conclude on Friday, December 5, at noon. More than 3,000 physicians are expected to be in attendance.

The A.M.A.'s Council on Scientific Assembly directs the meeting. The related, balanced program of lectures and clinical conferences will stress practical information for daily use by the general practitioner. Approximately 200 physicians will participate in lecture meetings, symposiums, and panel discussions on such subjects as neurology and psychiatry, cardiovascular disease, arthritis, orthopedics and various other medical topics. A new feature will be 10 round-table breakfasts.

The scientific portion of the program will be presented in the Minneapolis Auditorium, which will also house the 100 scientific exhibits and some 130 technical exhibits. Rooms within the Auditorium have been set aside for the showing of 35 medical motion pictures, and a symposium on proctology will be a special attraction on Wednesday evening, December 3. Closed circuit colored television will be shown again this year to doctors attending the meeting. Among the

November Cover



Medicine in Ancient Egypt

An Egyptian physician of the Eighteenth Dynasty (1500-1400 B.C.) clothed in clean white linen and a wig, as became the dignity of his status, is confronted with a patient having symptoms of lockjaw. With sure, sympathetic hands, the physician treats the patient. Directions for treatment appear on the scroll held by his assistant. Magico-religious rites are here being observed by priests specifically trained in this adjunctive specialty. (Courtesy of Parke, Davis & Company)

topics on the program originating in the Mayo Memorial Building of the University of Minnesota Hospital will be cardiac by-pass, neurology, orthopedic problems of the extremities, and cesarian section.

Another special feature of the meeting will be a trans-Atlantic conference between A.M.A. members in Minneapolis and British Medical Association members in Southampton, England. This program is scheduled for Friday, December 5. The British association will be holding a clinical session at that time.

At the Leamington Hotel, three blocks from the Auditorium, the House of Delegates will meet. Minnesota Gov. Orville Freeman will address the House of Delegates, and Dr. Horatio B. Sweetser, President of the Minnesota State Medical Association, will welcome the clinical assembly.

All hotel reservations should be cleared through AMA, Clinical Meeting Housing Bureau, Sixth Floor, Lutheran Brotherhood Building, Minneapolis 2, Minn., before November 22.

Conference for County Medical Society Presidents and Secretaries Jacksonville, December 14, 1958

Next month the Florida Medical Association will initiate a plan to bring together annually the incoming presidents and secretaries of all component county medical societies. President Jere W. Annis announces that the First Annual Conference for County Medical Society Presidents and Secretaries will take place at the Duval County Medical Society Building (Sellers Auditorium) in Jacksonville on Sunday, December 14. It will convene at 9 a.m. and adjourn about 4 p.m.

This meeting on an annual basis should prove most beneficial to the county societies and to the Association. All county societies will undoubtedly wish to be fully represented at this first meeting, and the Association requests that each society send in promptly the name of its president and secretary for 1959.

The program being arranged for this meeting should make it a most constructive and profitable occasion. Details of the program will be announced in the December Journal. Every incoming president and secretary of every county society in the state is urged to mark December 14 as an important date on his calendar and to begin now to make plans to attend the Conference.

University of Florida Teaching Hospital and Clinics Formally Opened in October

The University of Florida Teaching Hospital and Clinics formally opened for the admission of patients at 9 o'clock on Monday morning, Oct. 20, 1958. In brief ceremonies, Mrs. J. Hillis Miller, widow of the late University of Florida president for whom the J. Hillis Miller Health Center is named, cut a ribbon stretched in front of the doorway in the main lobby of the Hospital to mark the opening.

Presiding over the ceremony was Dr. J. Wayne Reitz, President of the University of Florida. More formal dedicatory rites are scheduled for the spring of 1959.

During the week prior to the opening, special tours of the imposing new facility were conducted for physicians, hospital administrators, members of the press, Florida legislators, Gainesville townspeople, and alumni of the University. Also scheduled were orientation programs for law enforcement officials and information personnel and ambulance operators in the area surrounding the Health Center physical plant.

The Hospital opened initially with one acute patient floor and the ambulant wing available for use. Plans call for the opening of an additional 50 beds each three months until the entire 400 bed Hospital is in operation. The outpatient clinics began operation on the opening day.

Opening of the Teaching Hospital and Clinics climaxed a six year project which began with the Health Center Study directed by Provost Russell S. Poor in 1952. Dean of Medicine George T. Harrell Jr., joined the University faculty in 1954 to develop the curriculum and assist in the planning of the Medical Sciences Building, completed in 1956, and the Teaching Hospital.

The College of Nursing will move from its temporary quarters in the Medical Sciences Building to permanent quarters in the Teaching Hospital and Clinics.

The $9.6 million facility was scheduled to open this fall in order that members of the first class in the College of Medicine might begin their third year of instruction in the clinical facilities of the Hospital and Clinics. Prior to the opening, students spent two days each week at the Duval Medical Center in Jacksonville pursuing clinical studies.

Florida Correspondents For The AMA News

The first issue of American Medicine's first newspaper has at this writing come off the press and been received with widespread interest and approval. Some 210,000 physicians will receive The AMA News bimonthly and peruse it with profit. From front page Capsules in the News to numerous feature articles and nine regular departments this new newspaper, published every other Monday by the American Medical Association, offers news of interest to the most discriminating reader.

The medical profession of course wishes this venture every success, but it will take more than good wishes on the part of the A.M.A. membership to make this means of disseminating information of maximum usefulness. The Editor, Jim Reed, invites physicians to suggest ideas for articles they would like to see published in their newspaper.

In addition, special correspondents will cover the medical news across the nation. The Florida Medical Association has assisted The AMA News in selecting three correspondents in Florida. They are Charles M. Meister, of the Jacksonville Journal, Jacksonville; Jack Oswald, of the Miami Daily News, Miami; and John L. Boyles, Capital Correspondent of the Miami Herald Bureau, Tallahassee. To have these outstanding Florida newspapermen accept the duties and responsibilities of this role in the medical news field is gratifying to Florida Medicine. Their task, however, will be lighter and their service more effective if they have the active cooperation of the Association's entire membership.

New Cover Series

With this issue, The Journal begins a new cover series depicting milestones along Medicine's march of progress across the centuries. The pictures are taken from "A History of Medicine in Pictures," a project undertaken by Parke, Davis & Company as a service to the medical profession and also as a means of helping the public to understand and appreciate more fully what the advances in Medicine down through the ages mean today in terms of the betterment of health and welfare throughout the world.

The author and director of this noteworthy project is George A. Bender. The paintings are by the internationally known artist, Robert A. Thom. This author-artist team has engaged in intensive research to assure accuracy and authenticity, and they have been assisted by many expert advisors and specialists in various fields of arts and sciences. It is a privilege to reproduce on the cover of The Journal this continuing series of original oil paintings commissioned by Parke, Davis & Company.

American Psychiatric Association South Eastern Divisional Meeting Miami Beach, Dec. 1-3, 1958

The Florida Psychiatric Society will be host to the first South Eastern Divisional Meeting of The American Psychiatric Association on December 1, 2 and 3 at the new Deauville Hotel, Miami Beach. Scientific papers and scientific exhibits will be presented on each of the three days, with evenings reserved for relaxation and enjoyment of a pre-Christmas holiday for physicians in attendance and their families. Special daytime entertainment has been arranged for the women by the woman's auxiliary to The Florida Psychiatric Society.

This is a rare opportunity to combine pleasure and a look at "Psychiatry of Tomorrow." On the pleasure side, the Deauville has everything—even the winter sport of ice skating for those who are homesick for a change to cool weather. There are two large swimming pools and a nine hole golf course. During the day there are fashion shows and water shows, and at night not one, but two night clubs. The cuisine is excellent. For added enjoyment, there is a four day all expense trip to Nassau December 4 to 7 for the low cost of $118.

The scientific papers cover a broad range of subjects which will interest not only the psychiatrists but other physicians—the general practitioner, the surgeon, the obstetrician—any who are concerned with the health of the total individual.

Outstanding speakers will present 31 papers. The academic lecture will be given by Dr. Francis J. Gerty, President of The American Psychiatric Association. One afternoon will be devoted to a program on "The Psychiatric Implications of Space Medicine," to be covered by the Staff of General Dan C. Ogle, Surgeon General of the United States Air Force, Washington, D.C. It is expected that a number of South and Central American physicians will attend.

For hotel reservations write Deauville Hotel, Miami Beach, or Austin Davies, Executive Assistant, American Psychiatric Association, 1270 Avenue of the Americas, New York 20, N. Y.

International College of Surgeons Southeastern Regional Congress Miami Beach, Jan. 4-7, 1959

The Southeastern Regional Congress of the United States Section of the International College of Surgeons will meet from Sunday noon, January 4, to Wednesday noon, January 7, 1959, at the Americana Hotel, Bal Harbour, Miami Beach. The scientific sessions will begin with breakfast a la carte from 7:30 to 8 a.m. and the program from 8 to 9 a.m. in each of the following specialties on Monday, Tuesday and Wednesday mornings, and in the afternoon on Monday and Tuesday: Anesthesia, Colon and Rectal Surgery, General Surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Plastic Surgery, Radiology, Thoracic and Cardiovascular Surgery, and Urology. At 9 a.m. and continuing on until 1 p.m. on Monday, Tuesday and Wednesday there will be a General Assembly with a General Surgery program.

Approximately 50 internationally known guest speakers have accepted a place on the program, including Drs. Charles P. Bailey and Harry E. Bacon, of Philadelphia; William L. Watson, Alexander Brunschwig, and Gerald H. Pratt of New York; Claude S. Beck, of Cleveland; A. Neal Owens, of New Orleans; Curtice Rosser, of Dallas; Philip Thorek, Edward L. Compere, and Ross T. McIntire, of Chicago; and Gershom J. Thompson, Winchell McK. Craig, and Edgar van N. Allen, of Rochester, Minn. All the Southeastern medical schools are contributing faculty members to the program, and Dean Homer F. Marsh, of the University of Miami School of Medicine, will address the opening session. Smith, Kline & French are sponsoring a closed circuit colored television operative program also. In addition, there will be cinema programs on Sunday, Monday, Tuesday and Wednesday showing new current surgical films.

A banquet will be held on Tuesday evening, January 6. Dr. Louis M. Orr, of Orlando, President-Elect of the American Medical Association, will be the featured speaker. The regular Americana Hotel entertainment will follow. The Bal Masque room will be reserved exclusively for the banquet that night.

Members of the American Academy of General Practice are cordially invited to attend this convocation. The Tuesday morning panel on "Immediate Management of Surgical Emergencies" has been arranged primarily for them. This panel will include: Moderator, Dr. McIntire; "Broad Discussion of the Problem," Dr. George F. Lull; "Abdominal Emergencies," Dr. Thorek; "Injuries of the Bladder and Genitalia," Dr. Thompson; "Emergencies in Injuries of the Chest and Heart," Dr. Bailey; "Fractures," Dr. Compere; "Injuries of the Face and Neck," Dr. Owens; "Injuries of the Jaw and Teeth," Dr. Jack H. Beckwith; and "Neurosurgical Emergencies," Dr. Craig. This program is approved by the American Academy of General Practice for Category 1 credit.

The registration fee will be $10. Those who send in prepaid or advance registrations will be eligible to request Orange Bowl football and parade tickets at the regular price. A limited number of these tickets has been secured.

The local committee chairmen are: Drs. Frank L. Meleney, Honorary Chairman; Harold O. Hallstrand, General Chairman; Ralph S. Sappenfield, Anesthesiology; DeWitt C. Daughtry, Cardiovascular and Thoracic Surgery; Claude G. Mentzer, Colon and Rectal Surgery; Joseph S. Stewart, General Surgery; Richard E. Strain, Neurosurgery; Richard C. Forman, and Ralph W. Jack, Obstetrics and Gynecology; Edward Norton, Ophthalmology; Francis W. Glenn, Orthopedic Surgery; George E. McKenzie, Otolaryngology; John R. Lewis, Plastic Surgery; Alfred G. Levin, Radiology, and Milton M. Coplan, Urology.

Bahamas Conferences

An attraction of the 1958-1959 winter season of interest to Florida physicians is a series of three conferences to be held at Nassau in the neighboring Bahamas. The Sixth Bahamas Medical Conference is scheduled for November 28 to December 18, 1958. A diversified program will be presented by distinguished lecturers which should have wide appeal to internists and general practitioners. The individual subjects will be presented for varying periods of time during the three week Conference. The First Bahamas Surgical Conference will be held from December 29,



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

1958, to January 17, 1959. The Serendipity Session will follow from January 18 to January 31, 1959.

All sessions will be held at the British Colonial Hotel. The registration fee is $75, and an official certificate of attendance will be issued to participants in the conferences. American citizens will not need passports. Hotel reservations at special rates may be obtained by writing to Bahamas Conferences, P. O. Box 4037, Fort Lauderdale, Fla., and further information about the conferences is available from Dr. S. L. Frank, Organizing Physician, 23 East 79th Street, New York 21, N. Y.

Central Repository for Medical Credentials

The World Medical Association has initiated a program which the American Medical Association commends to the attention of physicians throughout the nation. On July 1, 1958, the services of a Central Repository for Medical Credentials became available to doctors of the world. During war and national uprisings, medical records are often lost or destroyed. In consequence, many doctors are today unable to utilize their professional skills because of the loss or destruction of their original credentials and the lack of a protective service in which authenticated copies could be deposited. The World Medical Association has therefore undertaken a program to assure that the doctor will always be able to prove himself medically trained and fully accredited to practice medicine.

In the United States, the lifetime cost of the service on a one payment basis to the newly graduated doctor is approximately $60. An actuarial schedule has been established for doctors in the various age groups. A 10 year service rate is also available.

Repository officials suggest that the credentials deposited include official medical school record, medical diploma, and specialist credentials. American doctors should *not* send their original credentials, but should send photostatic, microfilm, or notarized copies of their original credentials.

Requests for forms and for additional information in regard to the Central Repository for Medical Credentials may be sent to The World Medical Association, 10 Columbus Circle, New York 19, N. Y.

Refund Due for Overpayment Of 1957 State Intangible Tax

Physicians who paid the extra assessment to their 1957 intangible tax are entitled to a refund of the extra tax for that year, since the Supreme Court of Florida has ruled that the extra assessment was unconstitutional. Application blanks for the refund have been sent to all those who overpaid their tax.

In most instances, refunds have already been made; however, the Intangible Tax Department of the State of Florida has estimated that there is close to a million dollars yet to be refunded. Application for the refund must be filed within one year from the time the tax was paid; therefore, physicians who paid the tax in November or December, 1957, may yet apply and obtain the amount of their overpayment.

Additional application forms may be obtained from the office of the local tax collector. The



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references:

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completed form together with the tax receipt should be sent to Mr. Ray Green, Comptroller, State of Florida, Tallahassee.

Surgical Seminar
College of Medicine, University of Florida

On January 15-17, 1959 a surgical seminar will be held at the College of Medicine and University Hospital in Gainesville. Speakers and topics have been selected so as to present material that has application to the practice of surgery. The first day the program will be devoted to problems in thoracic surgery, and the second day it will deal with specific surgical disorders of the alimentary tract. For the final half day a surgical-pathologic conference and surgical rounds are scheduled.

This seminar has been arranged by the Division of Postgraduate Education in cooperation with the Department of Surgery of the College of Medicine.

Physicians desiring to attend the seminar may contact the Division of Postgraduate Education regarding housing, registration and other details. Dr. William C. Thomas Jr. is director of the Division, and Dr. Edward R. Woodward is head of the Department of Surgery.

OTHERS ARE SAYING

Committee On Malpractice

Every patient that comes in to your office is a potential malpractice lawsuit. In fact, anyone that you talk to on the phone and offer medical advice may be the source of worry, embarrassment, or financial loss to you. Such is the state of the practice of medicine whether we like to admit it or not.

Many of you I am sure have read the recent articles in "Medical Economics" describing various incidents that led to litigation and/or settlement. The circumstances leading to the difficulty varied from cases where there was no basis whatsoever for a lawsuit, to poor record keeping, to prescribing over the telephone with poor results. As you read the case reports it is obvious that most of the physicians involved have been competent, careful, and hardworking. They practice much the same as you do and little dreamed they might become involved in a lawsuit until they were suddenly confronted with a letter from an attorney.

(Continued on page 574)



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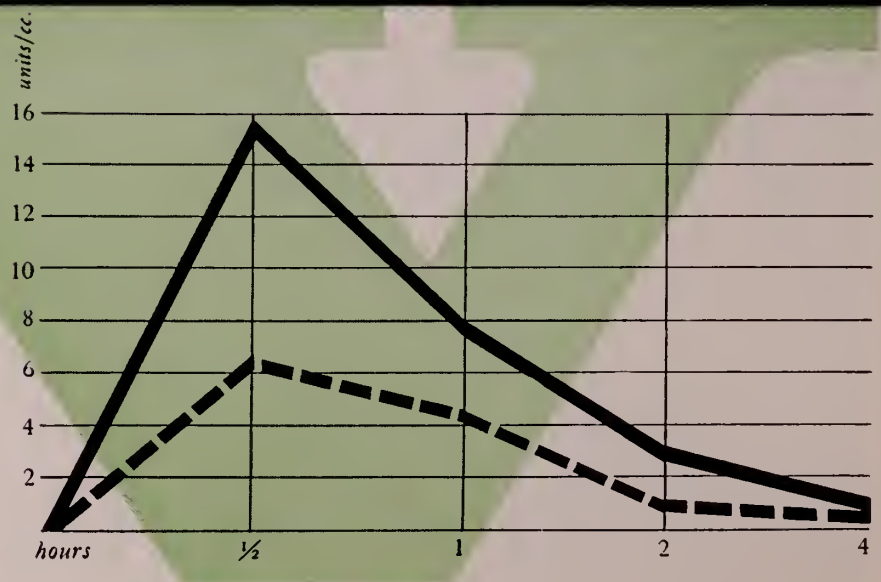
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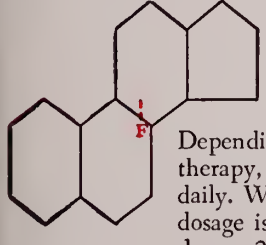
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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

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Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

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(Continued on page 568)

It is not enough to carry malpractice insurance because even if your coverage is sufficient to cover almost any conceivable judgment there is always the time involved in attorney consultations and the worry. If persons with spurious claims succeed in being paid off to forestall annoyance or embarrassment then others are encouraged to seek easy payoffs and we are repaid by an increase in our malpractice insurance premiums. At the present time the cost is almost astronomical and gives all indication of becoming higher if something isn't done to stem the tide.

It simply isn't enough to practice good medicine. Besides meticulous record keeping, careful supervision of your assistants, and being constantly alert to this problem there is another safeguard that can help with this problem. I refer to the formation of a malpractice committee. I know that there are many committees and the thought of another may be distressing to some, but many medical societies find this one of their most valuable committees. Its members vary according to the specific field of medicine involved in a particular dispute or lawsuit.

When a physician becomes involved in an incident that may lead to a lawsuit, besides notifying his insurance company, he should notify the chairman of this committee. The chairman then appoints others to the committee whose specific fields are involved such as radiology, orthopedics, etc. The committee members then meet with the concerned physician and try to ascertain the relative merits of the case. Following this the society's legal counsel is called in and all aspects of the case are discussed. The involved physician can then be advised as to the best course to follow.

The work of the committee is not to usurp the rights of anyone or to attempt to coerce a physician into a course that he may oppose. If the committee functions properly then valuable assistance can be had that frequently will cause a case to collapse before it really starts. If the case continues despite no merits then the entire society can stand behind the physician with the members of the committee giving expert testimony in court. If the case has merit then some settlement might be arranged so that undesirable publicity can be avoided. This problem concerns all of us and the odds are that each of us will be confronted with it specifically at some time. Let us stand together and approach this problem with intelligence and vigor.

Richard L. Foster
The Record,
Broward County Medical Association
February, 1958.

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there's pain and inflammation here, it could be mild or severe, acute or chronic, primary or secondary fibrositis or even early rheumatoid arthritis

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more potent and comprehensive treatment than salicylate alone

... assured anti-inflammatory effect of low-dosage corticosteroid [1]

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brings rapid pain relief; aids restoration of function

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Acetylsalicylic acid	325 mg.
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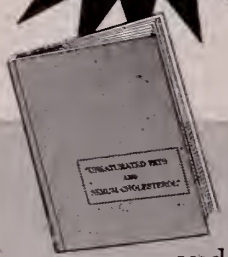
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ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

STATE NEWS ITEMS

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, addressed the members of the Board of Directors of the Florida Medical Secretaries and Assistants Association meeting in Tampa, October 10. On October 22, Dr. Annis attended the Fall Board Meeting and Conference of the Woman's Auxiliary to the Florida Medical Association held at Daytona Beach.

The Eighteenth Annual Meeting of the Gulf Coast Clinical Society was held October 23-24 at the San Carlos Hotel, Pensacola. Speakers included Dr. George R. Meneely, Associate Professor of Medicine, Vanderbilt University, Nashville; Dr. Goodrich C. Schauffler, Pediatric Gynecologist and Assistant Clinical Professor of Obstetrics and Gynecology, University of Oregon, Portland; Dr. William S. Kroger, Associate Professor of Obstetrics and Gynecology, Chicago Medical School, Chicago.

Dr. Louis K. Diamond, Associate Professor of Pediatrics, Harvard University, Boston; Dr. Jack N. Taylor, Assistant Professor of Urology, Ohio State University, Columbus; Dr. Edward R. Woodward, Professor and Chairman of Department of Surgery, University of Florida College of Medicine, Gainesville; Dr. John H. Moyer, Professor and Chairman of Department of Internal Medicine, Hahnemann Medical College and Hospital, Philadelphia; Dr. Deryl Hart, Professor and Chairman of Department of Surgery, Duke University School of Medicine, Durham, and Dr. Albert L. McQuown, Pathologist, Our Lady of Lake Hospital, Baton Rouge, La.

Dr. Lee Sharp of Pensacola has been serving as president of the Society and Dr. John J. Baehr Jr. also of Pensacola as secretary-treasurer.

Two faculty members of the College of Medicine, University of Florida, Gainesville, have been awarded grants to finance study in their respective fields. Dr. William W. Stead, Associate Professor of Medicine, has been awarded a $24,000 grant by the U. S. Public Health Service to finance a two year study for the development of an improved test of pulmonary ventilator function. Dr. Melvin Fried, Assistant Professor of Biochemistry, has been awarded a grant by the National Institutes of Health totaling $32,660 to

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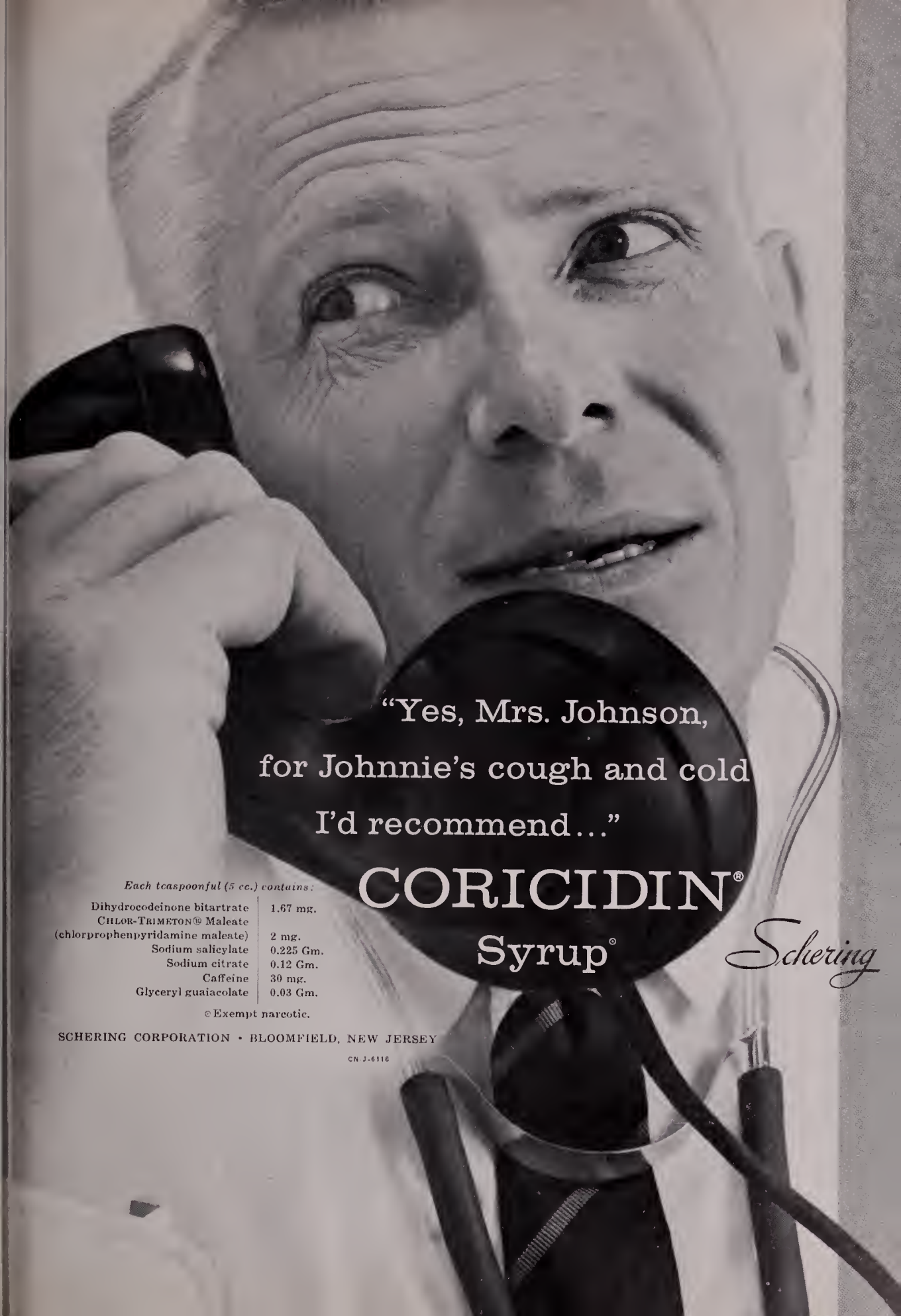
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finance a three year study devoted to the characterization of protein moieties of lipoproteins.

Dr. Mozart A. Lischoff of Pensacola has returned from a two month European tour. He attended the meeting of the American College of Surgeons in Stockholm, and visted clinics in Copenhagen and London. He also visited Edinburgh, Glasgow, the Brussels Fair, Paris and Madrid.

Dr. Robert E. Zellner of Orlando, president of the Orange County Medical Society, addressed the members of the Society's Woman's Auxiliary at their first meeting of the season held late in September. The title of Dr. Zellner's address was "Working for Better and Closer Relationships with our Medical Societies."

The third in a series of conferences on nursing service has been scheduled for Jan. 27-28, 1959 at the Seminole Hotel, Jacksonville, Fla., cosponsored by the Florida State Board of Nursing, the Florida Nurses Association, the Florida League for Nursing and the Licensed Practical Nurses Association of Florida. Consultants expected at the meeting include Mrs. Frances R. Kreuter, Professor of Nursing, Teachers College, Columbia University, and Miss Marguerite Kakosh, Assistant Professor, College of Nursing, Rutgers University.

Dr. Thomas H. Bates of Lake City has been installed as president of the Columbia County Unit, Florida Division of the American Cancer Society, and Dr. Robert M. Sasso also of Lake City as medical advisor.

Dr. Thomas D. Head of Crawfordville attended the Medical Progress Assembly and the dedication of the Southern Medical Association's headquarters building at Birmingham, Ala., the middle of September.

Drs. James A. Winslow Jr., William C. Blake and Hawley H. Seiler of Tampa have been appointed members of the board of directors of the Florida Heart Association. Dr. Winslow will also serve as a member of the research committee.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, was one of the

(Continued on page 586)

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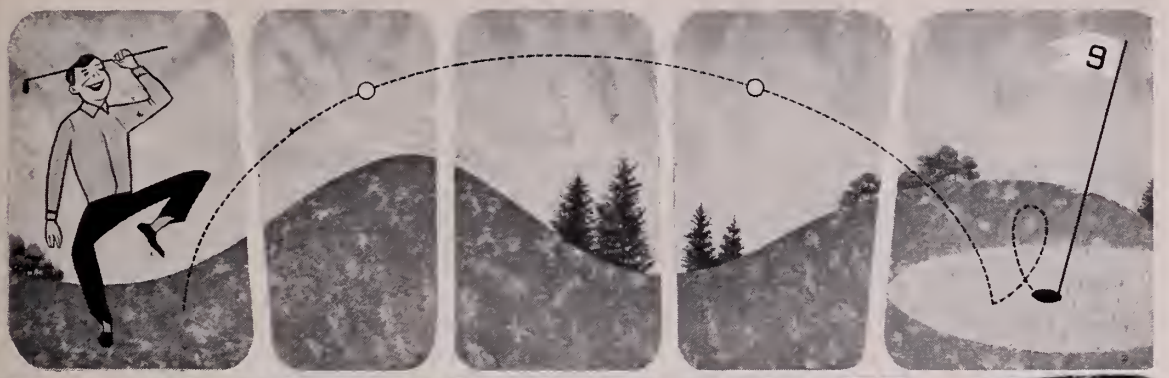
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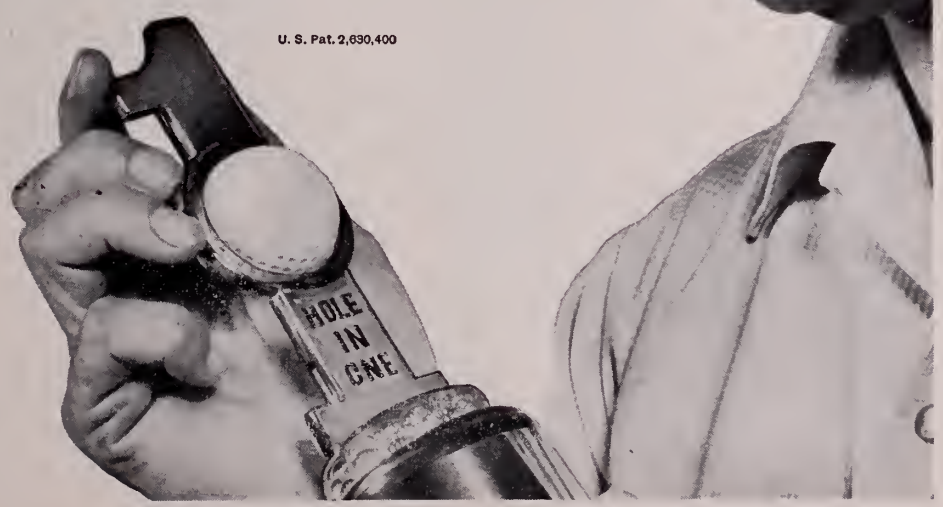
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Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
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(Continued from page 582)

principal speakers at the annual meeting of the Licensed Practical Nursing Association of Florida held the first of September at St. Petersburg.

Dr. S. Carnes Harvard of Brooksville has been appointed a member of the State Board of Medical Examiners by Governor LeRoy Collins. Dr. Harvard is First Vice President of the Florida Medical Association.

The United States Section, International College of Surgeons, will hold its Mid-Atlantic Regional Meeting at the Homestead, Hot Springs, Va., November 17-18. The scientific program will consist of ten papers, two panels and a sound movie in color. These will cover a wide range of subjects, with speakers from all parts of the country.

The University of Miami School of Medicine has received a grant from the United States Public Health Service for scientific equipment for its new research building scheduled for completion in late 1959. Dr. Homer F. Marsh, dean, stated that the grant would be matched by an equal amount from University and other sources.

Dr. Hyman Sporn of Hollywood has returned after spending the summer in Vienna where he did postgraduate work at the University of Vienna.

Dr. Milton M. Coplan of Miami has been chosen as chairman of the section on urology of the American Medical Association.

Dr. Fred H. Albee Jr. of Daytona Beach was one of the principal speakers at a workshop sponsored recently by the University of Georgia. The title of Dr. Albee's address was "Special Problems in Counseling the Severely Disabled Cerebral Palsied."

Dr. Edward S. Maxey of Stuart addressed the members of the local Rotary Club at one of their recent meetings.

Postgraduate courses in medicine, pediatrics, surgery, urology and anesthesiology are being offered this fall and winter by the University of Oklahoma Medical Center at Oklahoma City. Information and final programs may be obtained from the Office of Postgraduate Education, University of Oklahoma Medical Center, 801 N. E. 13th Street, Oklahoma City, Okla.

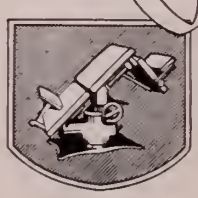


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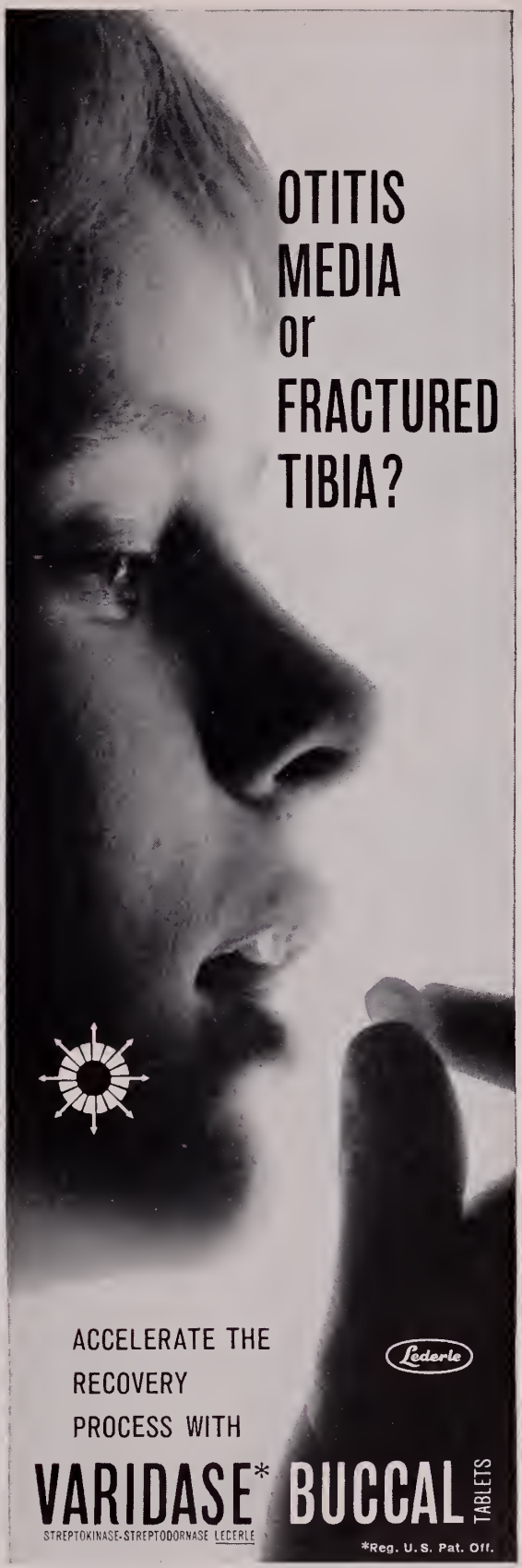
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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baldry, George S., Miami
Broussard, Elsie R., Pensacola
Caldwell, John M. Jr., Miami
Campbell, Richard K., Miami
Colvin, Irving L., Orlando
Davis, Joseph H., Miami
Flynn, Joseph C., Orlando
Forthman, Hugh J., Miami
Glucroft, Stephen H., Miami Beach
Hartley, William C., Hollywood
Helfrich, Norman A. Jr., Winter Park
Lefholz, Rothwell, Miami
Mahan, John W., Winter Park
Potyk, David, Orlando
Reiner, Ernest A., Tampa
Wagar, Anne W., Winter Park
Whiteside, James A., Coral Gables



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125 mg. per tsp. (5 cc.), 2 oz. bottle

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with 250,000 u. nystatin)

RAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-
'etracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline—analgesic—
antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

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EFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: nt. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. xp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., amford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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▮ a reliable defense against
monilial complications

both are often needed when
bacterial infection occurs



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It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

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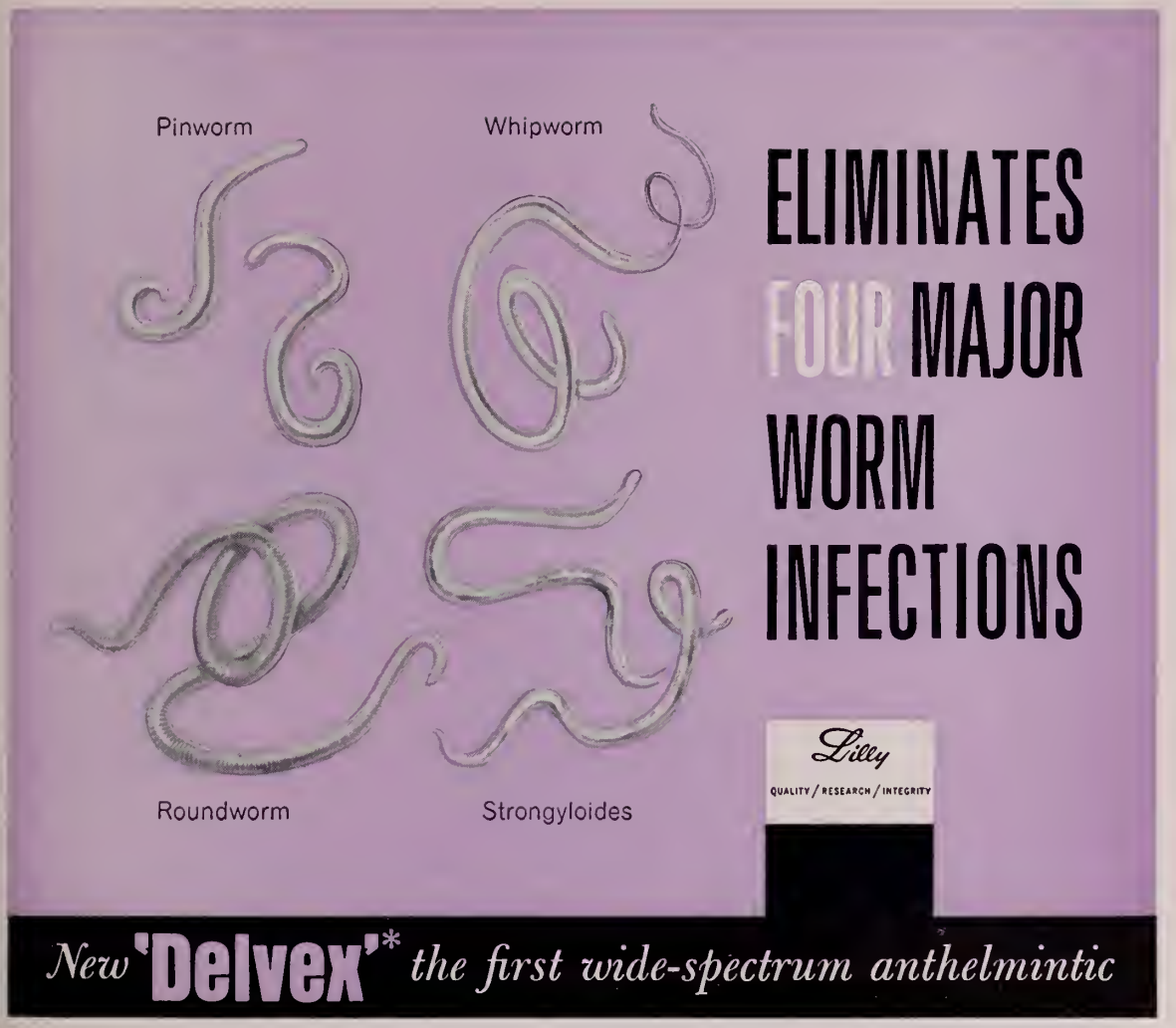
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• It eliminates pinworm infection in 100 percent of patients.

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1. Swartzwelder, J. C., et al.: J. A. M. A., 165:2063, 1957.

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Capsules
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treatment of moderately acute infec- in infants and children, the recom- dosage is 1 teaspoonful per 15 to of body weight per day, administered equal doses. Severe or prolonged require higher doses. Dosage for 2 to 4 teaspoonfuls 3 or 4 times daily, on the type and severity of the in-

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COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Glades

The DeSoto-Hardee-Highlands-Glades County Medical Society has paid 100 per cent of its state dues for 1958.

Jackson-Calhoun

Dr. William J. Knauer Jr., of Jacksonville, and Dr. John A. Moncrief, of Atlanta, were principal speakers at the annual scientific meeting of the Jackson-Calhoun County Medical Society held in Marianna early in September. Dr. Sarah M. Schulz, of Marianna, president of the Society, presided at the meeting which attracted physicians from the neighboring states of Georgia and Alabama.

Marion

The Marion County Medical Society held its September meeting at the Gainesville Golf and Country Club in Gainesville. The program consisted of a tour through the College of Medicine, University of Florida, and its teaching hospital conducted by Dr. George T. Harrell Jr., Dean, and the members of his faculty.

Sarasota

Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, was principal speaker at the September meeting of the Sarasota County Medical Society held at Sarasota.

MARRIAGES AND DEATHS

Marriages

Dr. James Imre Szabo of Orlando and Miss Mary Lou Nicholson also of Orlando were married there in September.

Deaths—Members

Fort, Chester A. Jr., Jacksonville ..... September 1, 1958
Winsor, Sanford A., Pompano Beach ..... September 2, 1958
Wilson. M. C., Miami ..... September 13, 1958
Smith, DeWitt T., Gainesville ..... September 23, 1958

Deaths—Other Doctors

Barry, Ray K., Miami ..... August 9, 1958
Brenner, Edward Christopher,
New York, N. Y. ..... July 24, 1958
Dickerson, Stephen B., Tampa ..... August 27, 1958
Goldberg, Samuel James, Fort Lauderdale ..... April 28, 1958
Joyce, Reid P., Xenia, Ohio ..... August 16, 1958
Lederman, Edward Isadore, Baltimore, Md. ..... June 7, 1958
Redman, William M., Miami ..... April 23, 1958
Rockman, Jacob, Miami Beach ..... March 19, 1958
Schaff, Burnett, Coral Gables ..... June 16, 1958
Scott, Wm. Wylie, Orlando ..... September 7, 1958
Stern, Max. E., Tampa ..... June 19, 1958
Takos, Michael J., Miami ..... September 9, 1958
Warren, George H., Perry ..... May 30, 1958
Weinstein, David, Opelousas, La. ..... June 29, 1958

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Vitamin A	5,000 Units*
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Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 m.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30–one month's supply
Boxes of 90–three months' supply or family package.

White's
WHITE LABORATORIES, INC.,
KENILWORTH, N. J.



Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

VALENTINE Company, Inc.
RICHMOND 21, VIRGINIA

Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 296 applicants who took the examination of the Board, held June 30, 31 and July 1, 1958 in Miami, 223 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 223 successful applicants follow:

Adler, Philip, Detroit (U. Vermont 1953)
Ainslie, John Durham, Gainesville (U. Calif. 1946)
Alaia, Louis Carlo, Jacksonville (St. U. New York 1956)
Anderson, Richard McLemore, Gainesville (Emory 1958)
Babb, Frank Shaleen, St. Paul (U. of Western Ont. 1938)
Bailey, Shirley Joseph, Jacksonville (M.C. Virginia 1957)
Balent, Alvan, Ft. Lauderdale (Temple U. 1957)
Baran, Alphonse Walter, Pontiac, Mich. (Wayne U. 1937)
Baum, Robert David, Miami (U. Miami 1958)
Bebout, Donald Edward, Boca Raton (Vanderbilt U. 1957)
Benson, John Richard, Biloxi, Miss. (Northwestern 1955)
Betagole, Samuel Leon, Miami Beach (Northwestern 1922)
Biddy, Ralph Leo, Pompano Beach (St. Louis U. 1958)
Blenke, Anna Mary, Miami (U. Tenn. 1957)
Borris, Marvin, Brooklyn (New York U. 1958)
Boyle, Playford Jr., Coytesville, N. J. (Jefferson 1954)
Brauston, Bruce Barry, Miami (U. Miami 1958)
Bresnick, Philip Alan, Miami (St. U., N. Y. Downstate Med. Cen. 1958)
Brown, William Thomas, Miami (U. Miami 1958)
Bruce, William Woodward, Coral Gables (U. Neb. 1939)
Bryant, Gerald Don Nelson Jr., Durham, N. C. (Duke U. 1953)
Bullard, Foster Lucius Jr., Marianna (U. Md. 1955)
Burgstiner, Carson Bertelle, Savannah, Ga. (U. Miami 1958)
Burman, Don Meredith, Deer Park, L. I., N. Y. (New York M. C. 1952)
Byers, Frank Matthew Jr., St. Petersburg (Duke U. 1957)
Callahan, George Sidney Jr., Miami (Emory 1958)
Carr, George Thomas, Belleville, Ill. (St. Louis U. 1955)
Carrera, Frank III, Tampa (Emory 1957)
Carroll, Maxwell Glenn, Crestview (Tulane U. 1952)
Churney, Otto Leonard, Coral Gables (Boston U. 1928)
Clark, Warren Adams, Louisville, Ky. (U. Louisville 1953)
Clement, Baxter Lee, Ft. Lauderdale (U. Tenn. 1930)
Cohen, Albert, Miami, (Ohio St. U. 1954)
Cohen, Floyd, Amarillo, Tex. (U. Cinn. 1955)
Colsky, Sol, Coral Gables (U. Tenn. 1956)
Colvin, Irving Laurent, Orlando (Indiana U. 1947)
Compton, William Andrew, Romulus, Mich. (Wayne U. 1953)
Connor, Gwendolyn Stone, Miami (M. C. of S. C. 1954)
Corson, Richard Howell, Miami (Temple U. 1957)
Courtney, Robert James, Tampa (Temple U. 1957)
Crowell, David Lloyd, New York (U. Penn. 1943)
Cunio, John Edgar, Miami (U. Miami 1958)
Curtin, Victor Thomas, Arlington, Mass. (Harvard M. S. 1953)
D'Alessandro, Domenic Richard, Detroit (U. Penn. 1950)
Dennis, William Paul, Esther, Mo. (U. Missouri 1957)
Diamandis, Themistocles John, Tarpon Springs (U. Miami 1958)
Dimmett, Robert Preston, Boonville, Ind. (Ind. U. 1952)
Dobbs, Olin Carl Jr., Jacksonville (M. C. Ga. 1957)
Doody, Thomas Marshall, Harahan, La. (Loyola U. 1951)
Drawdy, Robert Earl, Tampa (U. Miami 1958)
Dukes, Herbert Trice, Brandon (Duke U. 1955)
Eckley, George Morgan Jr., Wayne, Pa. (U. Penn. 1943)
Elchos, Theodore George, Panama City (Tulane U. 1952)
Evans, Fred Shields, Pensacola (U. Miss. 1957)



new 3-way build-up for the under par child...

Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate...plus sorbitol for enhanced absorption of both iron and B_{12}.

new INCREMIN* WITH IRON SYRUP

Lysine-Vitamins

delicious cherry flavor— no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	9.5 Gm.

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*Reg. U. S. Pat. Off.

Eversole, Earl Jr., Chapel Hill, N. C. (U. Tenn. 1951)
Fagerstrom, Charles Daniel, Eatontown, N. J. (U. Buffalo 1955)
Feibush, Joseph Sidney, New York (New York U. 1938)
Felsenstein, Morton, Miami (Hahnemann 1954)
Ferrara, Louis Vincent, Detroit (U. Chicago 1937)
Fisher, Alvin, Biloxi, Miss. (New York M. C. 1953)
Fisher, Harry, Homested Park, Pa. (St. Louis U. 1934)
Fleisher, Arthur Adler II, Los Angeles (U. Miami 1958)
Forrester, Eugene Norwood, Winter Park (Duke U. 1954)
Fulghum, James Elijah, Jacksonville (M.C. Virginia 1931)
Garner, Wade Hampton Jr., Sanford (U. Miami 1958)
Geiger, William Henry, Los Angeles (U. Miami 1958)
Gellin, Gerald Alan, Brooklyn (New York U. & Bellevue M.C. 1958)
Gerber, Paul Ulysses Jr., Miami (Vanderbilt U. 1958)
Giles, Roy Spencer, Miami (U. Miami 1958)
Glassberg, Joseph Edwin, Miami (Queens U., Belfast 1955)
Goddard, Arnold Robert, Surfside (U. Amsterdam 1957)
Gold, Donald Davis, Savannah, Ga. (M.C. Ga. 1958)
Gordon, Herschel Wallace, Miami Beach (Temple U. 1956)
Graditor, Milton Harry, Hollywood, (Hahnemann 1937)
Graupner, Robert Daniel, Sussex, N. J. (St. U. New York 1953)
Grinaker, Arne James, St. Petersburg (U. Miami 1948)
Grumer, Howard, Miami Beach (U. Miami 1958)
Guensch, Walter Alfred, Flushing, N. Y. (New York U. 1943)
Gurganious, Edgar Wallace Jr., Jacksonville (U. Miami 1958)
Gutierrez, Albert Richard, Homestead (U. Madrid 1951)
Hanahan, Marion Lothrop III, Dothan, Ala. (M.C. Ala. 1954)
Hardy, Douglas Frame, Orlando (U. Pittsburgh 1957)
Harris, Marvin, New Orleans (U. Miami 1958)
Hayslip, Gordon Woodrow, Boston (Bowman Gray 1950)
Heath, Hunter, New York (McGill U. 1943)
Hellinger, Richard Harriss, New Orleans (Northwestern 1956)
Henderson, Neil Carlton, Atlanta, Ga. (U. Md. 1956)
Hirschman, Jim Charles, Miami (Ind. U. 1955)
Hoke, Axel Werner, Tampa (Bowman Gray 1956)
Holley, Howard Lamar, Birmingham, Ala. (M.C. of S. C. 1941)
Honig, Alan Jay, Miami (U. Miami 1958)
Horrell, Eugene Dale, Tampa (Temple U. 1957)
Huckle, George Theodore, Cadillac, Mich. (U. Mich. 1953)
Jannotta, Frank Skiff Jr., Cradock, Va. (U. Penn. 1955)
Jarrell, Walter Gostin, White Springs (U. Miami 1958)
Jenkins, Wilburn Randall, Inverness (Emory 1958)
Joannides, Minas Jr., St. Petersburg (U. Ill. 1950)
Johnson, Albin Willard, St. Louis (Duke U. 1957)
Johnson, Julius Traylor, Augusta, Ga. (M.C. Ga. 1953)
Jones, Edwin Ladd Jr., Jacksonville (Emory 1958)
Jones, James Richard Jr., Orlando (U. Ga. 1947)
Jones, Walter Colquitt III, Miami (U. Miami 1958)
Jordan, Steven Ernest, Ft. Lauderdale (Emory 1957)
Justi, Raymond August, Miami (Loyola U. 1948)
Kean, Herbert, Philadelphia (Hahnemann 1956)
Keeler, William Henry III, St. Petersburg (Temple U. 1952)
Kelley, Virgil Roscoe, St. Petersburg (U. Ark. 1957)
Kennedy, James Randall, Claxton, Ga. (M.C. Ga. 1957)
Kiernan, Thomas Joseph, Coral Gables (Albany M.C. 1956)
Kimball, Sanford Garson, Miami (U. Miami 1958)
Kledzik, Ronald Bruce, Charlottesville, Va. (U. Va. 1958)
Korus, Hanns Claus, Miami (St. U. of Thuringia 1944)
Kramer, Jerome Allan, Miami (U. Pittsburgh 1958)
Krause, Seymoure, Pittsburgh (U. Pittsburgh 1943)
Lake, Doris Elizabeth, Sanford (U. Miami 1958)
Larson, Paul Urban, St. Louis (Washington U. 1952)
Lasky, Albert Stephen, St. Petersburg (U. Miami 1958)
Liebermann, Harry Max, Brooklyn (New York U. 1958)

(Continued on page 614)



NEW! TARCORTIN LOTION
excellent for lesions of head and hands
SUPPLIED: plastic squeeze bottles, ½ oz.

R&C REED & CARNRICK / Jersey City 6, New Jersey

1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.
5. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.

Comments by investigators on

Robaxin®

(Methocarbamol Robins, U.S. Pat. No. 2770649)

Robins



– the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

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Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
STUDY 1[1]					
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

Investigator

after investigator repor

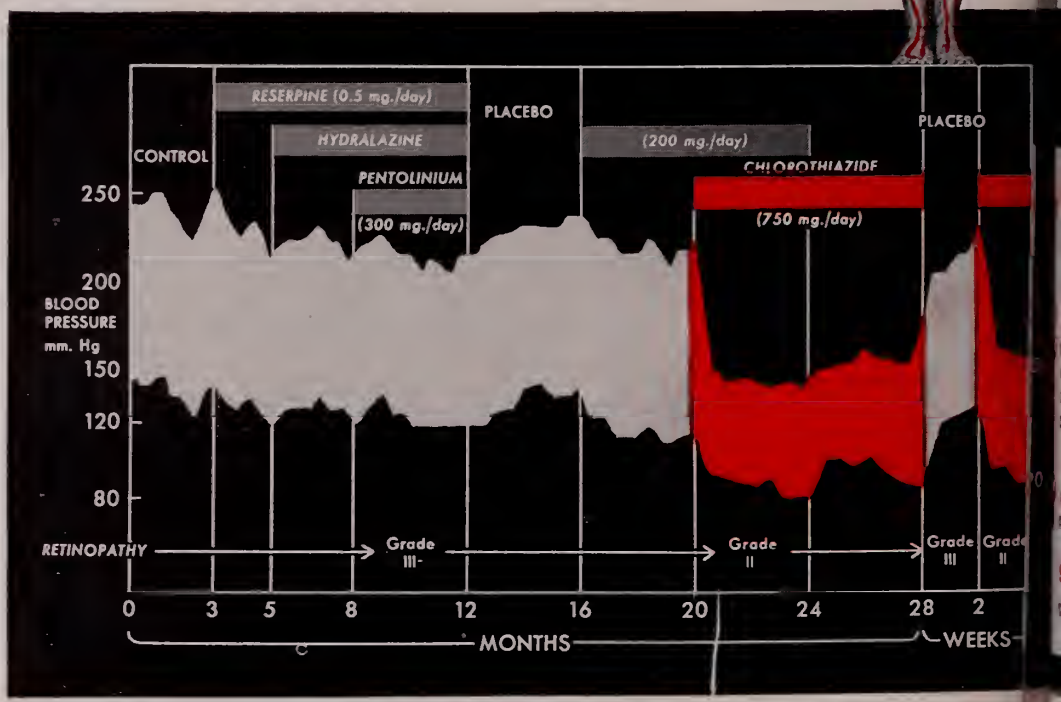
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8:1, Sept. [illegible] 57.

MERCK SHARP & DOHME Division of MERCK & CO., Inc., Philadelphia 1, Pa.

effectiveness of 'DIURIL'
(CHLOROTHIAZIDE)
in
Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'



Foods to give your patient good nutrition naturally—and tastefully, too!

The High-Vitamin, High-Mineral Diet

—and, with your consent, a glass of beer to make them even better

Shredded new cabbage and carrot slaw goes nicely with any meal, combining vitamins A, C, and calcium. Dried apricots and figs stuffed with cottage cheese and peanuts on watercress provide calcium, iron, vitamins A, B_2, niacin and C. Oysters are rich in iron, calcium and carry vitamins A and D, too.

Beef liver ranks high in iron, vitamins A and B-complex. Oatmeal, rich in iron, gets a calcium and vitamin B_6 bonus when served with molasses and milk. Custard contains calcium and vitamins A, B_1, B_2. A topping of orange juice concentrate adds Vitamin C.

And with a glass of beer*—at your discretion—your patient will find his diet interesting and ample without straying from your instructions.

*An 8-oz. glass of beer contains 10 mg. calcium, 50 mg. phosphorus, ½ minimum daily requirement of niacin, and smaller amounts of other B-complex vitamins. (Average of American beers)

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PRONOUNCED TAY-O

Tao*

(brand of triacetyloleandomycin with glucosamine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

Roerig Rx NEW YORK 17, N. Y.

Division, Chas. Pfizer & Co., Inc. SCIENCE FOR THE WORLD'S WELL-BEING

*TRADEMARK

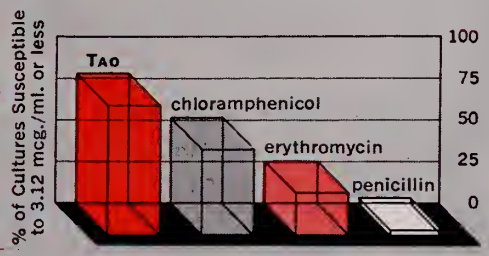
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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the painless intramuscular calcium

is the preferred vehicle of choice because of its ease of administration and its lasting effect. Complete literature on request.

Formula: A specially processed solution of Calcium Glycerophosphate and Calcium Lactate containing 1% of the ester and salt in normal saline with 0.25% phenol. Patent No. 2657172.

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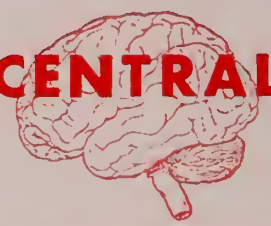
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Combines:
Central Antitussive Effect — mild, dependable
Topical Decongestion — prompt, prolonged
plus Antihistaminic and Expectorant Action

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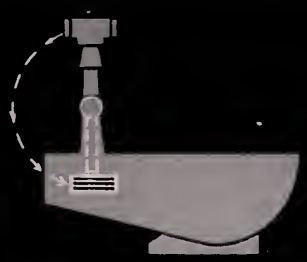
Each teaspoonful (4 cc.) contains:

[illegible]	10 mg
[illegible]	4.0 mg
[illegible]	1.0 mg
[illegible]	2.5.0 mg
[illegible]	70.0 mg
[illegible]	1.0 mg
[illegible]	0.02 cc
[illegible]	8%

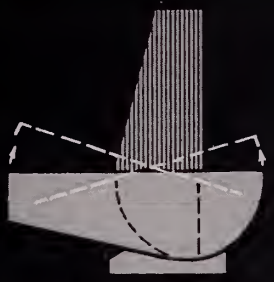
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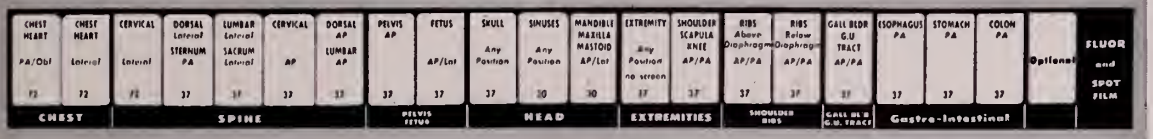


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That's all there is to it. No time, KV, or MA adjusting to do. No charts to check, no calculations to make.



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Modest cost
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From time immemorial physicians have been aware of the restorative powers of wine.

A Tasty Aid to Appetite and Digestion

A glass of Sherry at mealtime stimulates the jaded appetite, serves as a tonic and aids the digestion. As a postprandial or between-meals' beverage, a glass of Port has been warmly recommended for the sick and enfeebled.

Wine has been found to increase salivary flow and stimulate gastric secretion.

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The ease with which wine is metabolized makes it an important nutritive factor.

A Gentle Vasodilator and Sedative

The systemic sedative and vasodilative actions of wine can be of great aid and comfort to both the aged and the convalescent, particularly in the presence of cardiovascular disease.

These and other therapeutic uses of wine are discussed in the physician's brochure, "Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.



Now—the most widely prescribed tranquilizer[1] in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules



q. 12 h.

Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained* basis, without between-dose interruption

"The administration of meprobamate in sustained action form [Meprospan] produced a more uniform and sustained action ... these capsules offer effectiveness at reduced dosage."[2]

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

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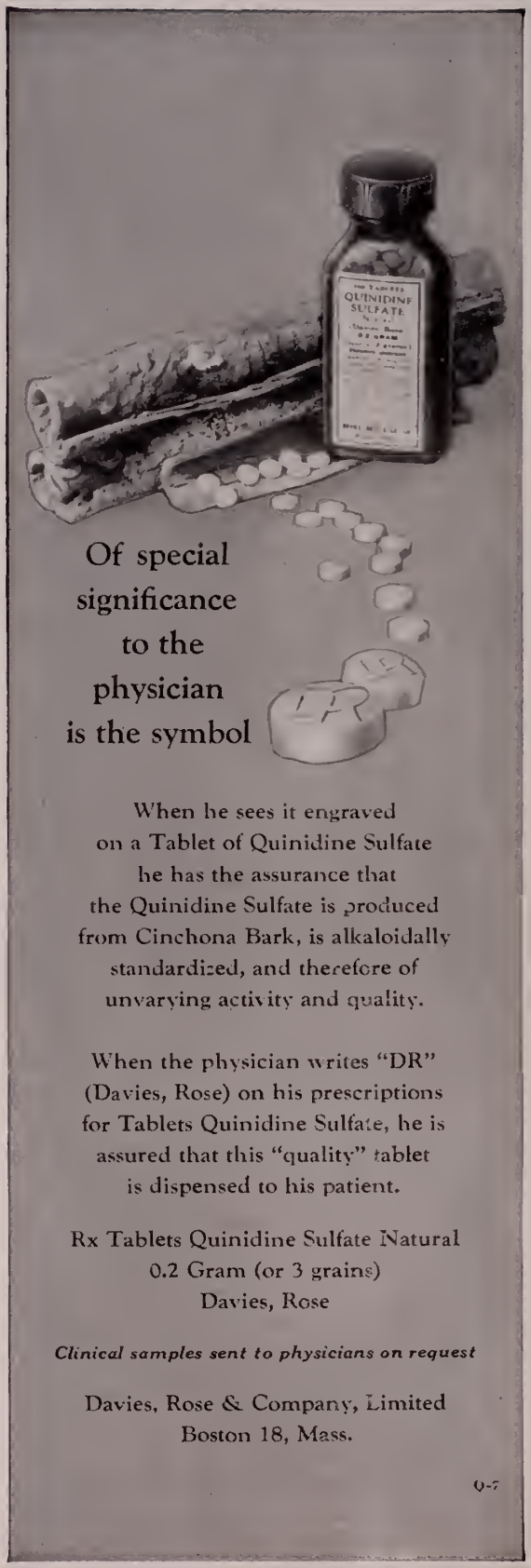
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Liebling, Martin Esmond, Bethesda, Md. (Washington U. 1955)
Logun, Albert, Miami (U. Miami 1958)
Lustgarten, Jack Gerald, Merrick, L. I., N. Y. (U. Iowa 1938)
McCann, James Walter Jr., Atlanta, Ga. (M.C. Ga. 1956)
McFall, John Samuel Robert, Coral Gables (M.C. Va. 1942)
McIlhany, Mary Lou, Lantana (Vanderbilt U. 1950)
McLendon, Irwin Chester, Hazelhurst, Ga. (M.C. Ga. 1955)
McMichael, Morton, South Windham, Me. (Johns Hopkins 1941)
Malgrat, James David, Key West (Vanderbilt U. 1958)
Mamlet, Laurence Norton, Miami Beach (U. Miami 1958)
Manthey, Richard Gledhill, Waterloo, Ia. (G. Washington U. 1951)
Martinez, Hubert Gregory, Miami (U. Miami 1958)
Mazzeo, Vincent Paul, Brooklyn (Long Island C. M. 1945)
Mazzola, Nunzio Joseph, Brooklyn (Long Island C. M. 1934)
Mezrah, Jack Morris, Tampa (Emory 1957)
Miller, Arthur Richard, Miami (U. Ill. 1957)
Miller, Richard David, Miami Beach (U. Chicago 1957)
Miller, Robert Freeman, Miami (U. Miami 1958)
Mills, Donald Wilson, Tampa (U. Miami 1958)
Milstein, Joseph Gerald, Miami (U. Miami 1958)
Moore, Anthony Joseph, Riviera Beach (Tulane U. 1957)
Moore, William Alexander III, Tampa (Creighton U. 1946)
Morgan, Marvin Wesley, Miami (U. Tenn. 1952)
Morrish, James Aubrey, Oak Park, Mich. (Wayne U. 1953)
Murtland, Richard Lee, Chapel Hill, N. C. (Jefferson 1950)
Naness, Charles Haskell, Miami Beach (U. Miami 1958)
Neller, Roth Dwight, Ft. Lauderdale (U. Miami 1958)
Nicolai, Karl Eric, Vero Beach (Hahnemann 1957)
Norton, Edward Walter Dillon, Miami (Cornell U. 1946)
Noto, Thomas Anthony, Miami (St. Louis U. 1957)
O'Connell, William Wayne, St. Augustine (Emory 1958)
O'Leary, Richard Gibson, Jacksonville (Albany M.C. 1954)
Peirce, Kenneth Edward, Neptune Beach (Tulane U. 1957)
Perry, Richard Edgar, Valdosta, Ga. (Hahnemann 1955)
Plummer, Richard Wayne, Mobile, Ala. (U. Miami 1958)
Polacek, Michael Andrew, Chicago (Northwestern 1957)
Prince, John Thomas, Park Ridge, N. J. (Ohio St. U. 1957)
Pulco, Anthony Joseph, Ft. Gordon, Ga. (Temple U. 1956)
Raftery, Michael, Lantana (National U. of Ireland 1947)
Ramey, James William, Mt. Sterling, Ky. (Duke U. 1954)
Read, William Lee, Winter Garden (La. St. U. 1952)
Reese, Norman Oliver, Chapel Hill, N. C. (U. Rochester 1952)
Reeves, John Dudley Jr., Boston (U. Ark. 1947)
Regan, Peter Francis III, Gainesville (Cornell U. 1949)
Reich, Theobald, New York (St. Louis U. 1951)
Reynolds, Arthur McKinley Jr., Arlington, Va. (M.C. Va. 1953)
Richardson, Joseph Bernal, Atlanta, Ga. (U. Md. 1953)
Richardson, Kenneth Wayne, Columbus, Ga. (U. Miami 1958)
Roberson, George Donald, Richmond, Va. (M.C. Va. 1958)
Roberts, Fred Fletcher, Coral Gables (Western Reserve 1957)
Rockwell, Elizabeth Kitchen, Tampa (U. Mich. 1939)
Rodensky, Paul Lewis, Miami (St.. U., New York, Syracuse 1955)
Ross, John Wells, St. Petersburg (U. Toronto 1923)
Rubin, Herbert Edgar, Gulfport (U. Ill. 1936)
Rubio, Fernando Antonio Jr., St. Petersburg (Georgetown U. 1950)
Ryon, Dale Sanford, Miami (U. Penn. 1957)



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Schocoff, Jack, Brooklyn (U. Miami 1958)
Schwartz, Arthur David, Miami (Washington U. 1956)
Seckinger, Daniel Lamont II, Miami (G. Washington U. 1954)
Segal, George Allen, St. Petersburg (U. Vermont 1952)
Seropian, Diran Menas, Rego Park, N. Y. (New York U. 1949)
Sheehan, Lucius Clyde Jr., Macon, Ga. (M.C. Ga. 1957)
Shultz, Clifford James, Orlando (U. Cinn. 1955)
Silberberg, Marvin Manuel, Miami (U. Miami 1958)
Silverblatt, Charles William, Coral Gables (U. Ark. 1945)
Silvius, Richard John, Miami (Temple U. 1957)
Simon, Roy Lindner, Ft. Lauderdale (Harvard M. S. 1929)
Sinnott, Richard Andrew Jr., Ann Arbor, Mich. (Yale U. 1953)
Slotkin, Marvin Bernard, Miami Beach (U. Tenn. 1956)
Smith, William Jr., Oklahoma City (M.C. Ga. 1951)
Smith, William Noble, Crummies, Ky. (U. Tenn. 1951)
Sobel, Harold John, Jacksonville (Chicago M.S. 1954)
Sokoloff, Burton Zelig, Miami (St. Louis U. 1958)
Spoont, M. Lawrence, Philadelphia (Northwestern U. 1956)
Staudt, Charles Edward, Bartow (U. Buffalo 1947)
Stead, William White, Gainesville (Emory 1943)
Stokley, Samuel Peter Hansen, Atlanta, Ga. (U. Miami 1958)
Storey, Ben Charles, Tampa (Ind. U. 1958)
Strasser, Hans Adrian, Kissimmee (Columbia U. Coll. P & S 1935)
Sugar, Max, New Orleans (U. Toronto 1948)
Swords, Jack Kenneth, Miami (U. Miami 1958)
Taubel, Louis Edward, Ft. Lauderdale (U. Penn. 1929)
Taylor, Paul Worden Jr., Opa Locka (U. Rochester 1953)
Taylor, William Jape, Allison Park, Pa. (Harvard M.S. 1947)
Tirman, Wallace Samuel, South Bend, Ind. (Long Island C. M. 1937)
Truitt, Robert Bulkeley, Miami (Northwestern U. 1952)
Vnuk, Wallace John, Jacksonville (U. Nebr. 1951)
Volinski, Thomas Joseph, Philadelphia (Temple U. 1953)
Walklett, William Donald, Atlanta, Ga. (Emory 1958)
Warner, Charles Ernest, Holly Hill (Duke U. 1958)
Waters, Dean Gale, Augusta, Ga. (Johns Hopkins 1956)
Watson, Allen Smith Jr., Miami (Loyola U. 1957)
Webster, Raymond Harris, Memphis, Tenn. (U. Tenn. 1958)
Weiss, Malcolm Howard, Miami Beach (Chicago M.S. 1958)
White, Richard Harold, Miami (U. Miami 1958)
Wilber, Robert Harold, Jeffersonville, Ind. (U. Louisville 1958)
Wilder, Buna Joe, Coral Gables (Duke U. 1955)
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Winter, Thorne Sherwood III, Atlanta, Ga. (Harvard M.S. 1958)
Wolcott, Mark Walton, Coral Gables (U. Penn. 1941)
Woodbury, Ralph Fairfield, Detroit (Wayne U. 1956)
Woodward, Edward Roy, Gainesville (U. Chicago 1942)
Wruble, Lawrence David, Miami Beach (U. Tenn. 1958)
Zawisza, Raymond Joseph, Miami (Georgetown U. 1956)

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BOOKS RECEIVED

Clinical Obstetrics and Gynecology; Volume 1, Number 2, **Toxemias of Pregnancy,** edited by Louis M. Hellman, M.D., and **Fibromyomas of the Uterus,** edited by Robert A. Kimbrough, M.D. Pp. 295-544. Price, $18.00 by subscription for four consecutive numbers. New York, Paul B. Hoeber, Inc., 1958.

This second volume (June 1958) of a new quarterly book series, started last March and entitled Clinical Obstetrics and Gynecology, follows the basic structure of two symposiums per issue, one on a subject of clinical interest in obstetrics and one in gynecology. There are 31 distinguished contributors. The subjects presented in the symposium on Toxemias of Pregnancy are: fundamental aspects of fluid metabolism, fluid and electrolyte metabolism in toxemia of pregnancy, the renal excretion of sodium in women with preeclampsia, peripheral vascular bed in toxemia, circulation of the brain in toxemia, the uterine circulation in toxemia, pathology of the placenta in toxemia, endocrine aspects of toxemia, prophylaxis against toxemia, treatment of eclampsia and preeclampsia, renal disease and hypertension in pregnancy, and causes of maternal death in toxemia. Those covered in the symposium on Fibromyomas of the Uterus include: symptoms and signs of fibromyomas of the uterus, uterine adenomyosis and adenomyoma, benign and malignant changes in uterine myomas, effects of uterine myomas on the urinary tract, general considerations in the treatment of myoma uteri, radiation therapy for myoma uteri, myomectomy, vaginal hysterectomy for uterine myomas, technique of vaginal hysterectomy for myomas uteri, abdominal hysterectomy for uterine myomas, uterine fibromyomas and sterility, and myoma uteri associated with pregnancy.

Stedman's Medical Dictionary. Edited by Norman Burke Taylor, V.D., M.D., F.R.C.P.(Can.) M.R.C.S. (Lon.), in collaboration with Lieut. Col. Allen Ellsworth Taylor, D.S.O., M.A., Classical Editor. Pp. 1656. Price, $12.50. Baltimore, The Williams & Wilkins Company, 1957.

This nineteenth revised edition of Stedman's Medical Dictionary includes words used in medicine with their derivations and pronunciation including dental, veterinary, chemical, botanical, and other special terms; anatomical tables of titles in general use, the terms sanctioned by the Basle Anatomical Convention; the new British anatomical Nomenclature; nomina anatomica, revised by the Fifth International Nomenclature Congress of Anatomists; pharmaceutical preparations official in the United States and British Pharmacopeias or contained in the National Formulary; and biographical sketches of figures in the history of medicine. Several thousand of the new medical terms created since the last revision four years ago are included in the new edition. A number of illustrations have been added and many of the old ones redrawn. The names of pharmaceutical preparations have been changed from Latin to English in conformity with the latest editions of the United States and British Pharmacopeias.

The Essence of Surgery. By C. Stuart Welsh, M.S,. M.D., Ph.D., and Samuel R. Powers, Jr., A.B., M.D., M.Sc.D. Pp. 320. Illus. 50. Price, $7.00. Philadelphia, W. B. Saunders Company, 1958.

In this most unusual delineation of the fundamental concepts of Surgery the authors succeed in exposing a basic framework of universally useful principles that do not change. They set forth as a primary thesis the idea that all surgical management measures are merely variations of fixed principles. The variations are dependent upon type of injury, anatomic location of injury and state of the body. The same principles of treatment apply whether a condition involves neuroscurgery or gyneco-

(Continued on page 622)

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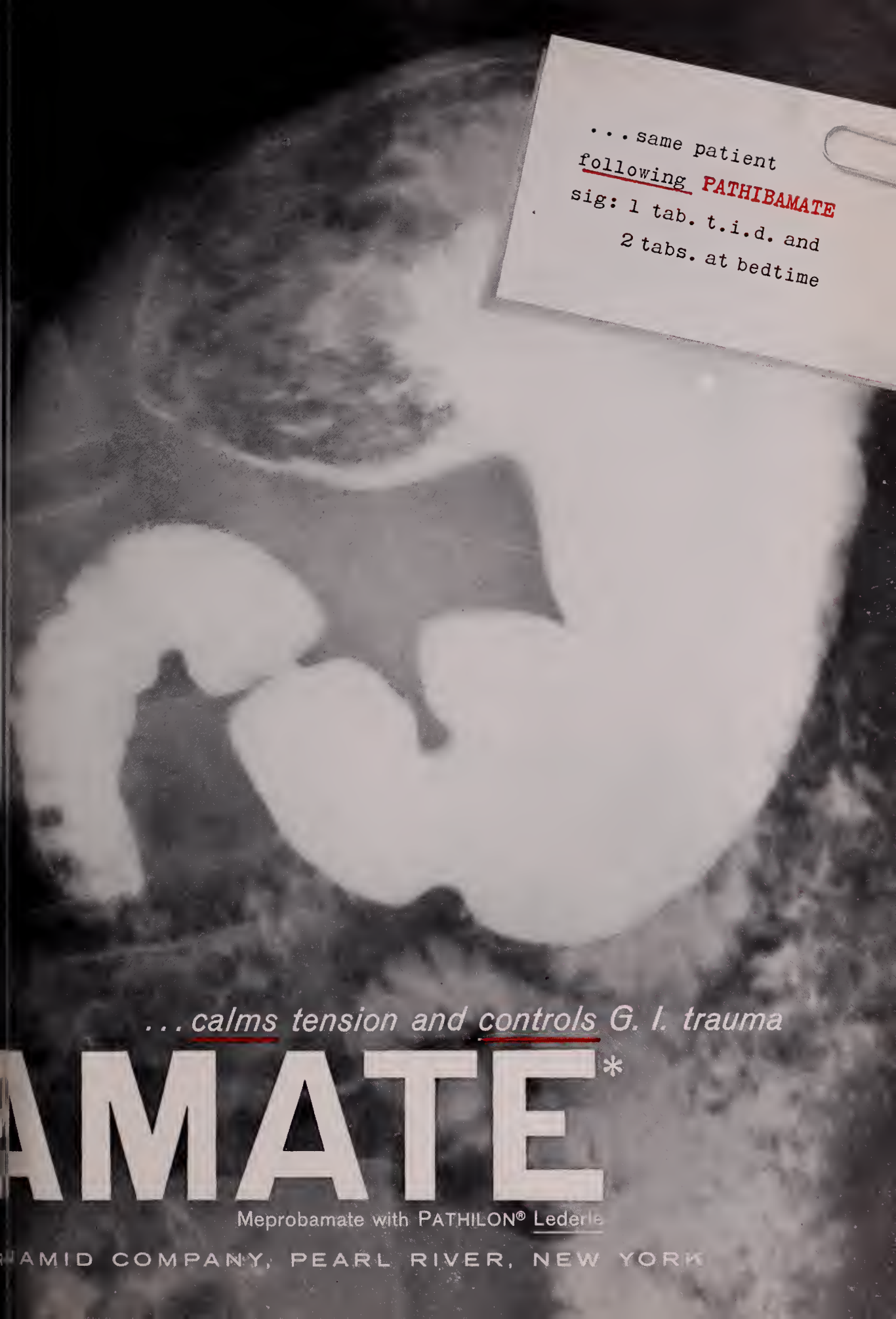
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(Continued from page 618)

logic surgery. By reducing all injuries to (1) loss of body tissue, (2) loss of body fluids and (3) infection, they approach surgical injuries from this limited point of view, making many previously obscured problems become more simplified and manageable. Because of this sameness in all acute injury, an understanding of the fundamental corrective measures is a vital prerequisite before going on to specific variations of treatment methods. The fundamentals are beautifully spelled out in this book.

The section on Fluid and Electrolyte is one of the most lucid ever published. Among the many hints and helps in operative technic are unusual suggestions on tissue handling, manipulation of instruments and sutures. Emphasis is placed on the important role of nonoperative surgery and the increasing interest in the problems of surgical infection. Separate chapters illuminate significant aspects of Physiologic Surgery and of Anesthesia. Students, surgical residents, surgeons and general physicians doing some operative work should all find this book a remarkable new tool for understanding surgery.

Hospital Accreditation References. Pp. 136. Price, $3.25. Chicago, American Hospital Association, 1957.

The need for a comprehensive collection of accreditation literature for use as a reference by those seeking specific information about the hospital accreditation program has long been apparent. One of the most useful instruments yet devised for improving hospital care, this program has become most influential as a potent force in encouraging good hospital care. As such it is the strongest arm of freedom for the voluntary hospital system. As a part of this program, the American Hospital Association has rendered timely and important service by publishing this volume of accreditation references. It contains only official expressions of the Joint Commission on Accreditation of Hospitals as they have appeared in print or in unpublished correspondence. The book is arranged by subject following the pattern of the Standards for Hospital Accreditation. Thus, everything the Commission has to say about governing boards, medical staff organization, medical records, pharmacy, et cetera, can be found readily in this volume under the appropriate heading.

Emergency Treatment and Management. By Thos. Flint, Jr., M.D. Ed. 2. Pp. 539. Price, $8.00. Philadelphia, W. B. Saunders Company, 1958.

This book offers the physician ready assistance in coping with the sudden accident and the unexpected medical crisis. It covers practically every medical emergency requiring a quick decision and fast action, and the topics are listed and indexed alphabetically for speedy reference. Instructions on therapy are simple, precise and thorough. An introductory section on General Medical Principles and Procedures offers help in handling barbiturate and narcotic prescriptions, blood alcohol tests, rape and assault cases, suicide, serum sensitivity and tetanus immunization. The second section on Emergency Treatment of Specific Conditions covers over a hundred emergency situations ranging from abrasions and contusions to coronary attacks and psychiatric emergencies. The third and final section on Administrative, Clerical, and Medicolegal Principles and Procedures presents needed information on abandonment, birth and death certificates, court testimony, emergency case logs, malpractice, operative and treatment permits, photography of patients, release of information, release from responsibility, reportable diseases, public liability cases and responsibilities of the physician treating emergency cases. This practical section can be most helpful in protecting the physician from negligence suits in handling emergency cases.

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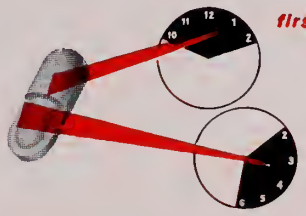
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vasopressor resistant shock and arterial damage. The greatly expanded section on Pediatric Emergencies emphasizes those conditions in which there is a decided difference in treatment between children and adults. Many recently developed fungicides and insecticides are included in the section on Poisonings, and there is a new and simplified discussion of the potential emergencies likely to arise from nuclear warfare. This handy volume should be most useful to any physician.

Healthful School Living. A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants. Editor, Charles C. Wilson, M. D. Pp. 323. Price, $5.00. National Education Association and American Medical Association, 1957.

Healthful School Living completes a trilogy of publications relating to the school health program which began with Health Education, published in 1924 with subsequent revisions in 1930, 1941 and 1948, and was continued with School Health Services in 1953. These three works complement one another in supplying teachers, school administrators, physicians, dentists, nurses, and others concerned with the health of the school child, with a synthesis of medical and educational viewpoints.

This particular volume emphasizes solutions to health problems affecting pupils as they live and learn at school. Useful information is gathered here on such matters as school housekeeping, the prevention of accidents, water supply and waste disposal, heating, ventilating, and lighting. Chapters are included on the health aspects of the school lunch, school building construction, and physical education. There are significant suggestions for teachers and administrators on health problems involved in the organization of the school day, the health implications of various classroom procedures, and the special needs of rural schools. Here is presented in an integrated manner the consensus of present-day leaders in education, medicine, public health, engineering, architecture, nutrition, safety, and related fields.

Cortisone Therapy: *Mainly Applied to the Rheumatic Diseases.* By J. H. Glyn, M.A.(Cantab.), M.D., M.R.C.P., D.Phys.Med. Pp. 162. Price, $10.00. New York, Philosophical Library, Inc., Publishers, 1957.

This work is the result of several years of intensive study in this country and England of the use of Cortisone and its associated drugs, primarily in the treatment of the rheumatic diseases. The author discusses from practical experience the relative values of Cortisone, Corticotrophin, Hydrocortisone, Prednisone and Prednisolone. The effects of treatment, the advantages and disadvantages, the indications and contraindications, the technic of withdrawal, are analyzed, and a broad general picture is produced which should be of great value to everyone undertaking treatment with these new and powerful preparations. Special chapters are devoted to local therapy, and an appendix describes in detail the technics for intra-articular and soft tissue injections from the anatomic point of view. The book also contains a review of steroid therapy in general medical, dermatologic and ophthalmologic conditions.

A Guide to Human Parasitology for Medical Practitioners (Blacklock and Southwell). Revised by T. H. Davey, O.B.E., M.D. (Belf.); D.T.M. (Liver.). Ed. 6. Pp. 222. Illus. 119. Price, $7.00. Baltimore, The Williams & Wilkins Co., 1958.

As with previous editions, this sixth edition of this useful manual is intended for the practitioner who, from time to time, will need to make a diagnosis in diseases caused by animal parasites, and also for students of tropical medicine, tropical hygiene and public health. It is designed particularly for those who have no laboratory near them at which parasitologic diagnosis is undertaken. Here are to be found the salient features of the common pathogenic parasites of man, in any climate, presented in a simple and concise way, and the methods of diagnosis are rapid and easily learned. This new edition contains brief descriptions of Toxoplasma and Isospora, some parts of the text have been rearranged, the diagrams of life histories of the helminth parasites have been grouped according to the mode of entry into the human body, and a new diagram of the life history of the malaria parasite replaces the previous one.

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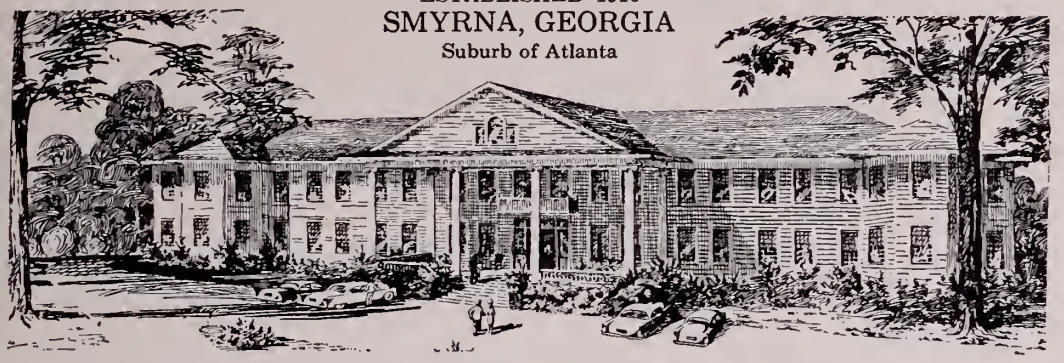
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Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	63
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	2nd Tues.	31
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	1st Tues.	61
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	2nd Tues.	221
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	3rd Wed.	13
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st. Tues.	921
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	27
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st. Tues.	351
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	114
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	237
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	14
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	33
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	80
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	7
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	33
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	36
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	15
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	9
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	230
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Herman Baxt, W. Palm Beach	4th Mon.	169
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	289
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	128
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	13
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Reuben J. Plant Jr., St. Augustine	3rd Tues.	22
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	84
Seminole	Daniel H. Mathers, Sanford	Vann Parker, Sanford	2nd Tues.	17
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	6
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	94
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	30
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLV DECEMBER, 1958 No. 6



M S D

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AGAINST THE UBIQUITOUS HOSPITAL STAPHYLOCOCCUS

CHLOROMYCETIN

Staphylococci are notorious for the variety of infections they cause and for their ability to develo resistance to certain antibiotics.[1-3] According to recent *in vitro* studies, however, these stubbor pathogens remain sensitive to CHLOROMYCETIN.[3-8]

Highly effective against most strains of staphylococci, CHLOROMYCETIN has been reported value in treatment for such serious infections as staphylococcal pericarditis,[9] antibiotic-resistan postoperative wound infections,[10] antibiotic-resistant breast abscesses,[3,11] pneumonia due t antibiotic-resistant staphylococci,[12] postoperative staphylococcal enteritis,[13] and septicemia.[14,1

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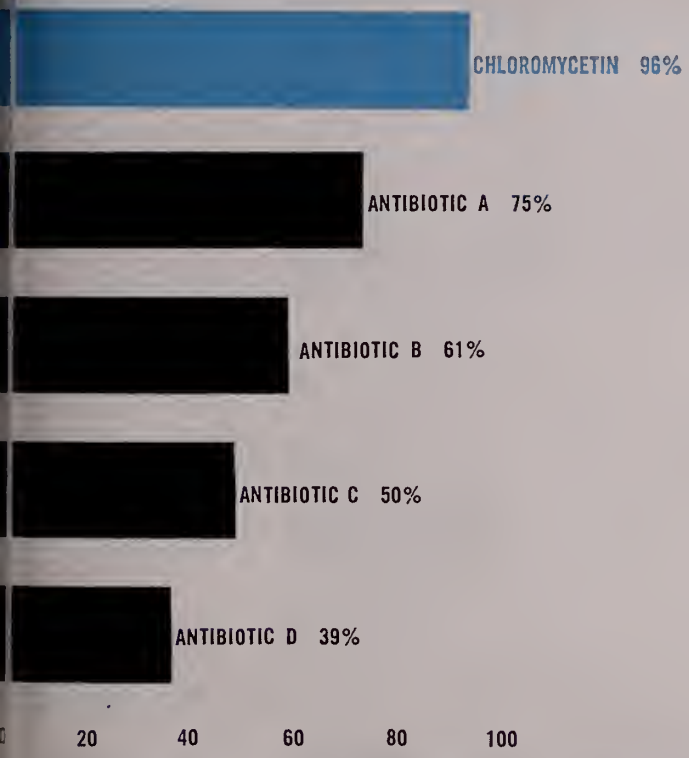
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I VITRO SENSITIVITY OF PATHOGENIC STAPHYLOCOCCI
T CHLOROMYCETIN AND TO FOUR OTHER MAJOR ANTIBIOTICS*



apted from Godfrey & Smith.[1] Staphylococci studied were strains isolated from 28 patients in a general hospital.

The Journal of the Florida Medical Association

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VOLUME XLV, No. 6 • *December, 1958*

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(1) Hasselborn, A. B.: Proc. Staff Meet. Mayo Clin. 32 703 (Dec. 11) 1957.
(2) Best, W. R., Lewis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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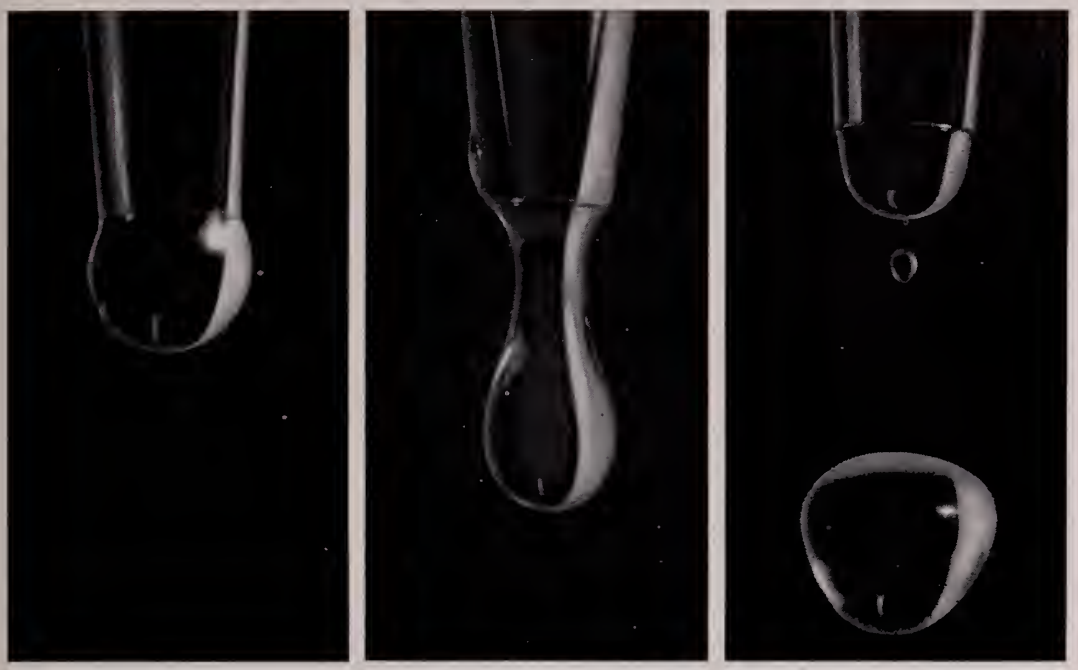
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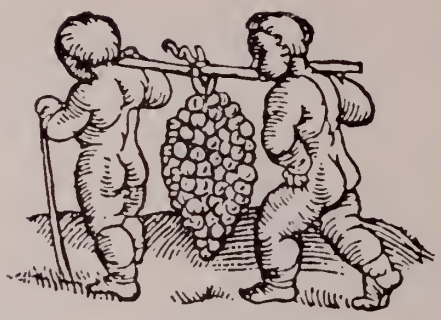
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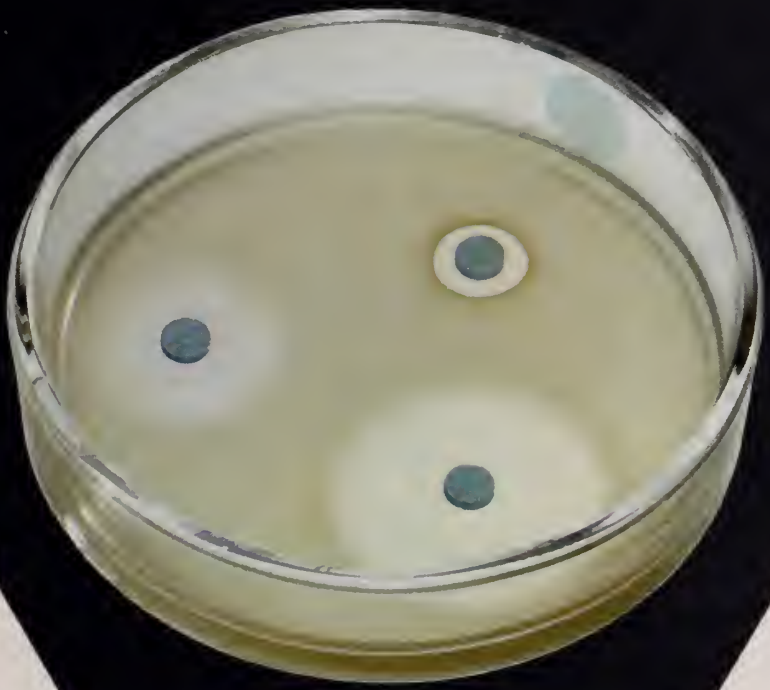
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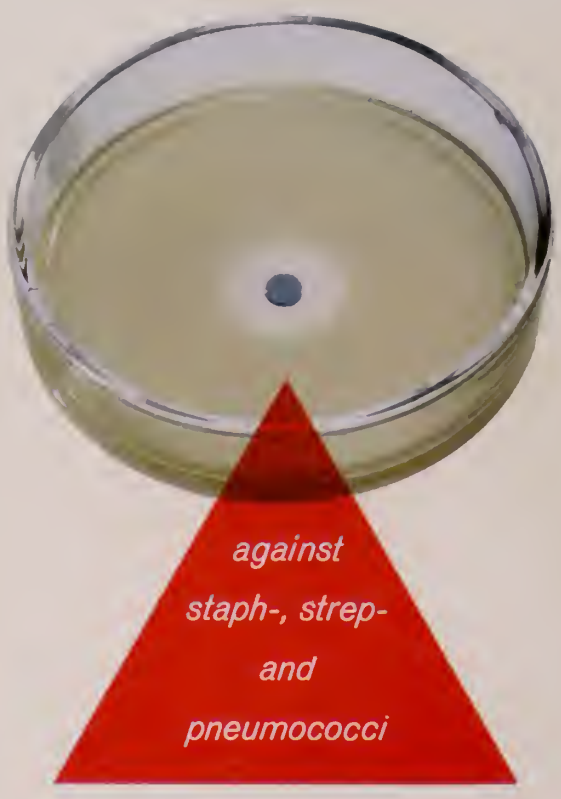
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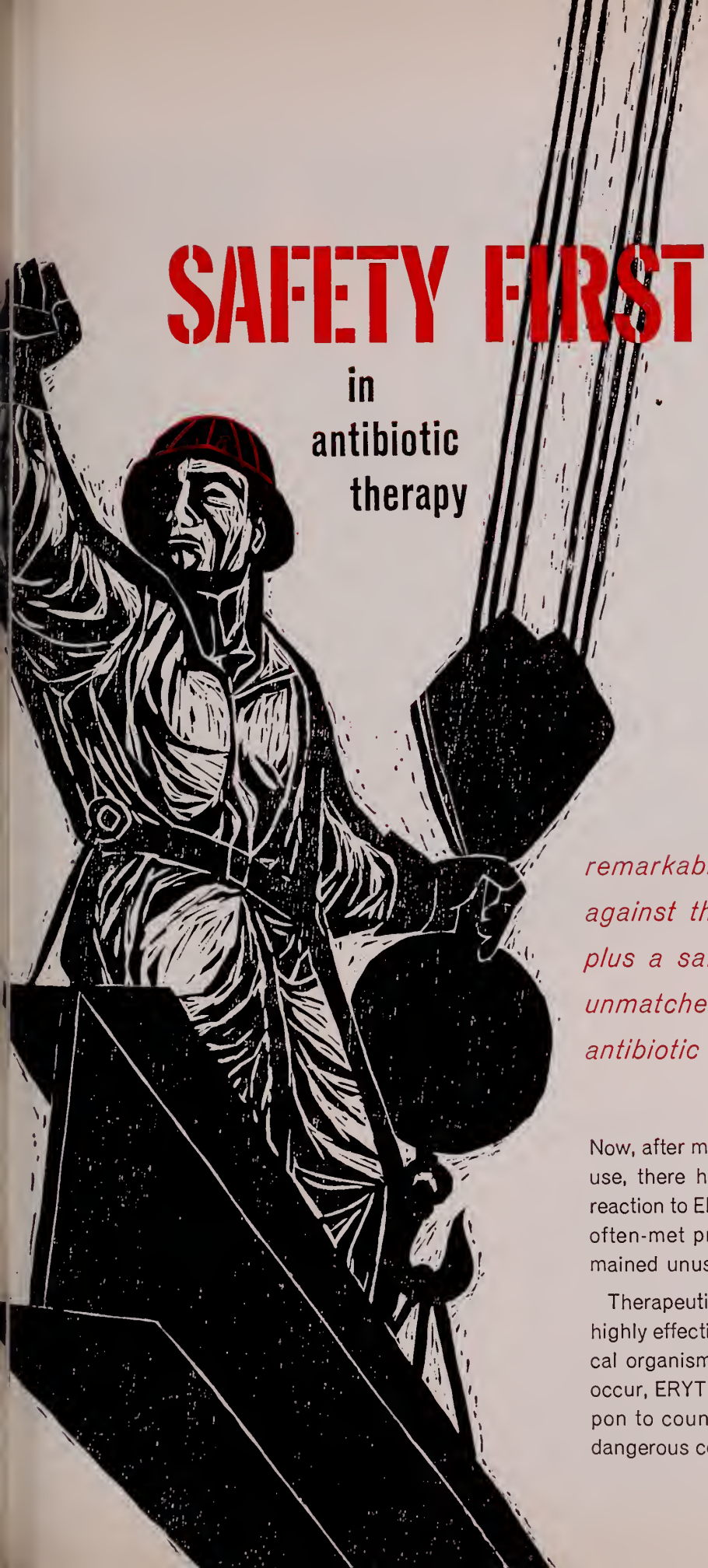
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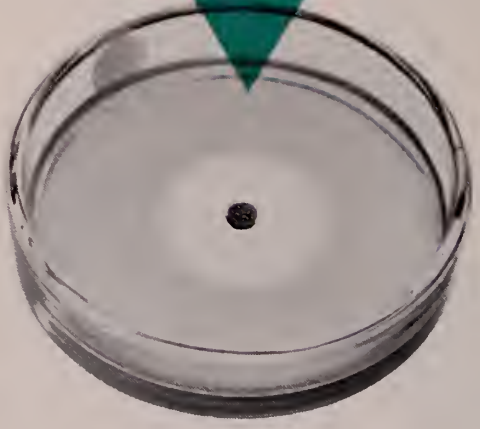
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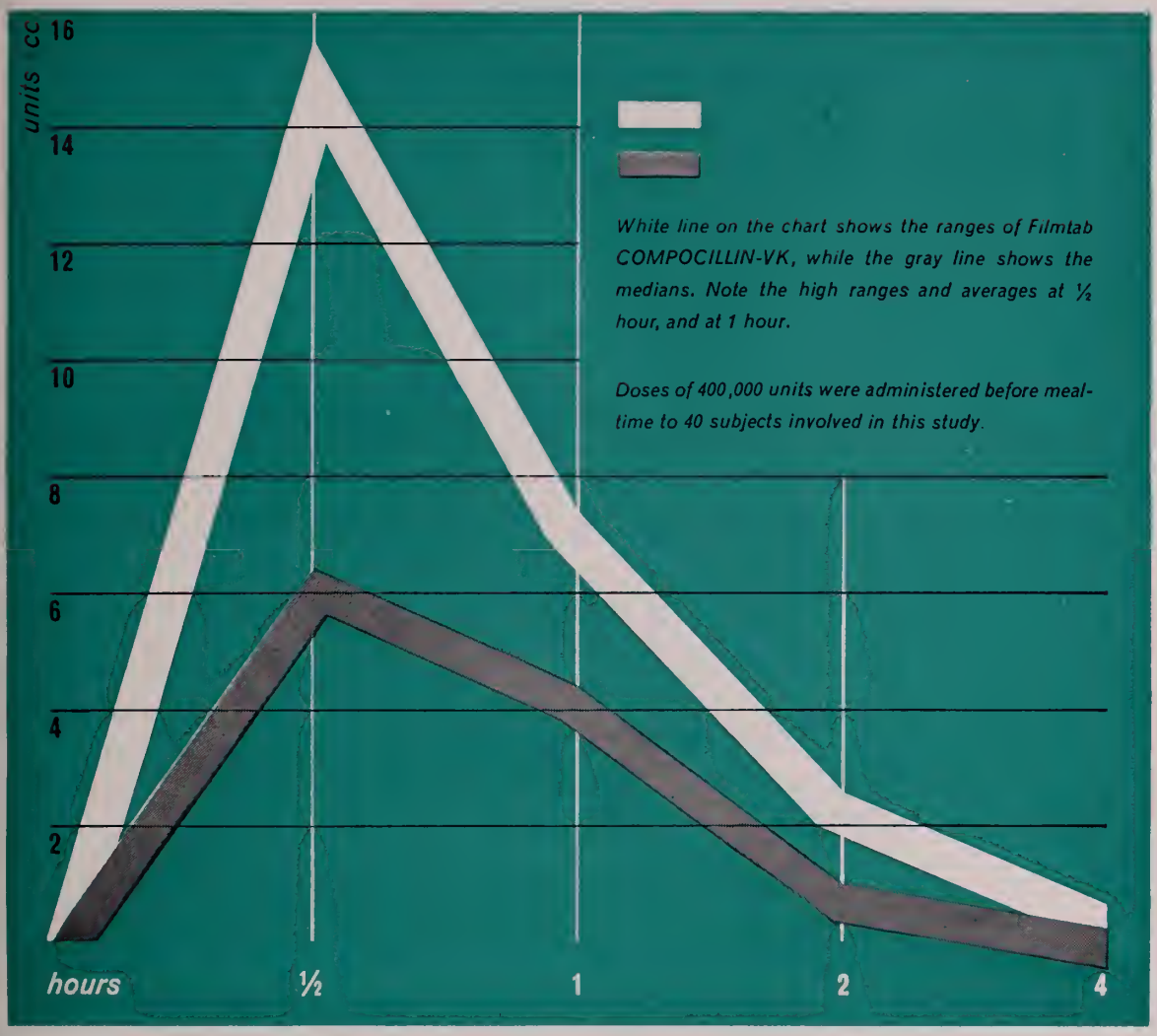


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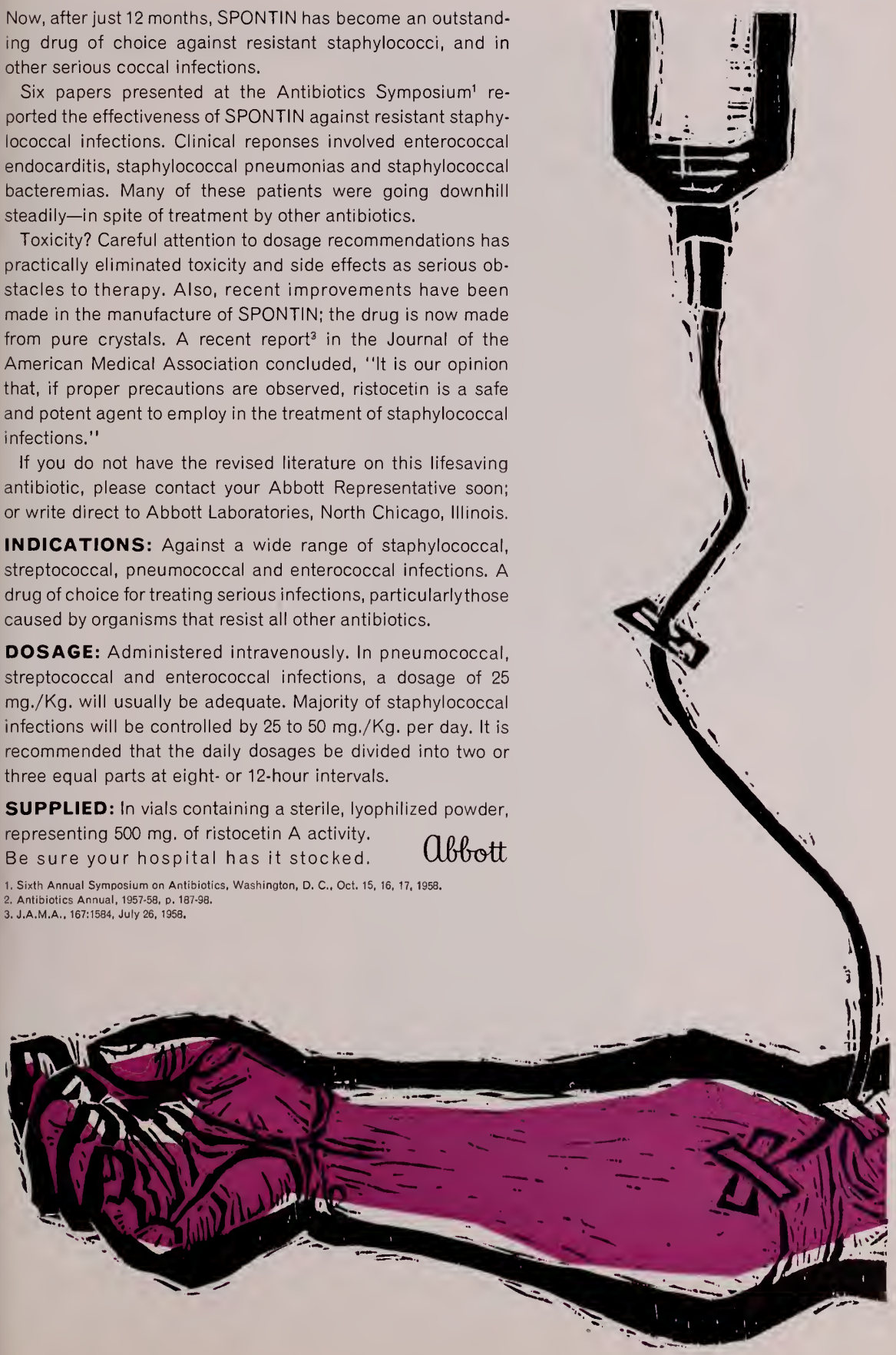
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references:

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False Positive Pregnancy Tests Caused by Sparine and Thorazine

GERARD H. HILBERT, M.D.
PENSACOLA

During the past decade the use of the frog test for the diagnosis of pregnancy has become increasingly popular and in many areas it is the only test used for this purpose. The main advantages of the frog test over the Friedman test are that quicker results can be obtained, the procedure is simpler, and the test animals are easier to handle and less expensive. Many investigators have shown that highly satisfactory results can be obtained with the frog test.[1-5] The thousands of negative controls recorded in the literature attest to the specificity of this test.[5-9] False positive results have rarely been reported. The occurrence of a false positive result in the Sacred Heart Hospital laboratory in May of 1957, as here reported, led me to the investigation of this problem.

Report of Case

A 27 year old white woman was admitted to the hospital with the clinical picture of an acute condition within the abdomen demanding immediate operation. Her complaints were cramping abdominal pains, vomiting and slight abdominal distention. She was not critically ill. On the second hospital day slight vaginal bleeding developed. A frog test performed on the fourth hospital day was reported as giving positive results. The diagnosis of a ruptured ectopic pregnancy was entertained, and a laparotomy was performed. The operative and pathologic findings were a severe pelvic inflammatory disease with bilateral chronic salpingo-oophoritis. A panhysterectomy was performed. No evidence of pregnancy was found. On the fourth postoperative day, a frog test was repeated and again gave positive results.

Materials and Methods

As a means of attempting to find out the cause of the false positive reactions, I investigated the medications which the patient had received during her hospitalization. My attention was brought to the drug Sparine because this was one of the few drugs which she had continuously received. On reading the pamphlet published by the manufacturers of this drug, I noticed under the heading of subacute toxicity that in feeding experiments in rats, the pituitaries, adrenals and gonads of both sexes had increased in weight. Specimens of urine of two other nonpregnant women receiving Sparine were given the frog test, and both gave false positive results. Further studies consisted of the testing of specimens from 16 additional nonpregnant patients receiving Sparine and 11 receiving a somewhat similar phenothiazine compound, Thorazine. These are two commonly used tranquilizing drugs and were the only ones tested. Out of the total of 30 frog tests, false positive reactions were obtained in 43 per cent—five in the 11 patients receiving Thorazine and eight in the 19 patients receiving Sparine. Ten of the total tested were men. All of the patients were adults. On several of the patients, the frog test was repeated a few days after the drugs were discontinued, and the results became negative. The daily dosages of the drugs varied from 50 to several hundred milligrams. The direct injection of dilutions of these tranquilizing drugs into the test animals failed to produce the emission of spermatozoa or a positive reaction.

On three patients, serum specimens were drawn on the same day that false positive tests were obtained on urine specimens. These serum specimens failed to produce a positive reaction to the frog test when injected into the test animal. Three of the urine specimens which produced false positive frog test results failed to stimulate corpora lutea formation in the ovaries of virgin doe rabbits, thus giving a negative reaction to the Friedman test.

All of the urine specimens injected were prepared by the kaolin absorption method. The enzyme Wydase was added to serum specimens prior to their injection into test animals.[10]

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

Discussion

Until recently the only significant difficulty encountered with the frog test as recorded in the literature was a seasonal change in the sensitivity of the commonly used Rana pipiens male frog. Because of this it has been recommended that the Rana clamitans frog be used as the test animal during the summer months. Robbins and Parker[10] in 1949 published a report on the positive reaction of male frogs to the injection of epinephrine. They believed that this reaction to epinephrine, while of great interest, seemed unlikely to be a cause of false positive pregnancy tests because to their knowledge epinephrine had never been identified in urine. In October 1957, Foxworthy and Lehman[11] reported that patients receiving Sparine gave a false positive reaction to the male frog test 75 per cent of the time. The study included both male and female patients. This, I believe, is the first report of a commonly used drug producing a high incidence of false positive results. Other false positive tests have been reported in recent years, but they are very few and are unexplained.[2,3,12]

Summary and Conclusions

Realizing that the number of cases presented are few and the additional investigations are on a small scale, I believe there is good evidence that therapy with Sparine and Thorazine will produce in a significant number of patients a false positive reaction to the frog test for pregnancy when urine is used as the test material. The failure of serum specimens to produce a similarly false positive reaction to this test and the failure of urine specimens to produce a positive result in the Friedman test tend to indicate that the substance producing the false positive result is probably an excretory by-product of these drugs, and it is most probably not due to an abnormal hormonal stimulation in the body. It is recommended that when a frog test for pregnancy is desired, serum in preference to urine be used as the test material when the patient is receiving a phenothiazine compound such as Sparine or Thorazine.

In interpreting a laboratory report, the clinician should always keep in mind the possibility that presently used medications as well as newer drugs to come may interfere with various laboratory determinations.

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Sacred Heart Hospital.

Discussion

DR. DANIEL O. HAMMOND, MIAMI: As a practicing clinician in the field in which great numbers of pregnancy tests are utilized, I am obviously interested in the circumstances which may contribute to loss of validity of this diagnostic aid. In addition, the theoretic considerations involved in this study raise questions which are cogent, significant and provoking. As for the first point, one must comment over and over again that the pregnancy test, like many other tests run on animals, is just a laboratory test. The astute and careful physician must learn that tests may err and that he must interpret their results. He must also be prepared to ignore or at least to question their results if they run counter to the clinical circumstances in the patient under consideration.

So much for the philosophy of diagnosis. As for the problem at hand, it has been known for a long time that many drugs have interfered with proper pregnancy testing by acting as toxic agents on the animals. Thus, barbiturates, sulfonamides, quinine and other agents have been among the proscribed materials in the usual instructions to patients about to undergo testing. Certain sexual hormone substances have been suspected of interfering with valid testing results. Dr. Hilbert mentioned the two papers that suggested for the first time the possibility that chemicals unrelated to the sexual steroids might by their very metabolism in the human body cause false results. There are other circumstances that are of interest in this area. Several reports have appeared in the literature showing that the phenothiazine derivatives mentioned and another closely related compound, Trilafon, may be responsible for the induction of pseudopregnancy or at least a strong decidual reaction in rats and other test animals. These studies have as yet not been applied to the human.

One must then question the mechanism of these effects. Dr. Hilbert thinks that in patients receiving Sparine who had false positive urine tests, the absence of false positive tests from serum indicated that the metabolic excretion products of the drugs were responsible. As Dr. Hilbert has already suggested, the number of patients subjected to this control study were few, and one might wonder whether these findings were simple chance. In addition, the fact that the urines were concentrated ones and that there is a sensitivity threshold involved in the animals would lead one to wonder whether the chorionic gonadotropin levels in the serums were high enough. In addition, complete gonadotropin deterioration has been observed at room temperature in as short a time as four hours. Moreover, Foxworthy also tried direct injections of Sparine into the test animal, as did Dr. Hilbert. Al-

though Dr. Hilbert did not specify, Foxworthy diluted these drugs in urine before injecting, in order to control this particular variable. Since these factors are operating, I do not believe that one can so easily rule out the possibility that a significant increase in gonadotropins may occur and may lead to the faulty test.

This conjecture is reinforced when one reads of acute effects of tranquilizing drugs on the anterior pituitary-ACTH mechanism. This is a situation in which increased pituitary trophic effects can be easily measured. Thus, studies by Harwood and Masen, (Endocrinology 60: 239, Feb. 1957) of circulating blood levels of 17-hydroxy-corticoids in monkeys following administration of chlorpromazine showed elevation of this product of the adrenal cortex. These authors concluded that "whatever specific sites are involved in the drug action, it is apparent from the data that the net effect of low doses is stimulation of the anterior pituitary-ACTH system while high doses fail" to do so. Parenthetically, reserpine was found to be the most effective. Furthermore, Trilafon has been found to interfere consistently with the menstrual cycle of adult rats (Vilardo, J. T.: Fertility and Sterility 9:60, Jan. 1958). Since a progestational compound must be secreted by the corpus luteum in the intact animal in order to induce a decidual reaction, the distinct possibility occurs that increased luteotrophic gonadotropins are released. One might theorize, to mention only one of the many side lines opened by this study, as to the possibility of controlling functional uterine bleeding by stimulating or reinforcing the effect of the corpus luteum with these drugs. This would surely establish a psychologic basis for the consideration of abnormal menses.

It is a pity that, as of now, no chemical laboratory assay of gonadotropins is available. This would make the search for the cause of the phenomenon less of a dilemma. Perhaps the new labeling technics might make available phenothiazine labeled with C14 or other atoms that would assist in the elucidation of the metabolism of the new ataractics. This type of study is sorely needed, partly because of the wide use of these drugs without full knowledge of their fate in the body, and partly because these studies would possibly lead to some of the answers for the problems of the cause and cure of mental disease. It may be that by studying the mechanism of treatment, one may discern the cause of mental illness.

Dr. Donald L. Foxworthy, Tampa: In discussing Dr. Hilbert's presentation of this most interesting and thought-provoking subject, I should like to dwell on two aspects of this problem. The first is misdiagnosis and resultant surgery that may occur, and the second is the awareness needed by all physicians to look for similar false positive laboratory results as drugs become more complex and more widely used.

Some physicians with whom I have discussed these false positive laboratory findings have thought them curiosities. To those who practice obstetrics and gynecology, however, these results necessitate a greater use of our diagnostic ability to prevent unwarranted surgery when a clearcut diagnosis based on physical findings is not apparent. Ectopic pregnancy is of course the greatest surgical emergency in which misdiagnosis could be based on a false positive test. In Dr. Hilbert's case report and in one of the case reports in my paper of October 1957, the decision to perform surgery may partially, if not wholly, have been based on the positive pregnancy test reported. The tranquilizers mentioned in Dr. Hilbert's report can cause a false positive laboratory finding in a significant percentage of cases, and if we, as physicians, are not aware of the possibility of these drugs reacting as they do, misdiagnosis is surely to become more common as the use of tranquilizers increases.

These facts just mentioned lead to the second portion of my discussion concerning the need for our awareness as physicians of the possibility of other drugs causing false positive laboratory reports, not only in pregnancy tests but in many other laboratory procedures that are normally considered specific. Our pathologists are always looking for these abnormalities, but are not always as fortunate as Dr. Hilbert in being able to determine the cause or even recognizing these problems unless they are brought to the attention of the laboratory personnel by practicing physicians.

Perhaps in the future more reports of the type Dr. Hilbert has presented today will show us that other drugs can give false positive laboratory results. We, as physicians, should remember that the laboratory reports only its findings and these coupled with a most careful clinical evaluation of the patient should determine our therapy.

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A Clinical Study of a New Cerumenolytic Agent

MANNING J. ROSNICK, M.D.
MIAMI

A commonly encountered troublesome condition in clinical practice is the occurrence of excessive cerumen with frequent impaction of the earwax. While cerumen is a normal secretion of the ceruminous glands, it may in certain susceptible persons be secreted in excessive amounts, become inspissated and plug the auditory canal.[1] Despite the fact that it is "nature's provision for the removal of dust and other foreign material from the canal of the ear,"[2] it may cause a variety of symptoms, the chief of which is deafness. Once it begins to accumulate, a plug is formed rapidly.[3] The sequelae of impaction are as extensive as they are damaging.[2-4] Many of the medications which have been used for softening and removal of the wax not only have proved ineffective but also have brought about undesirable effects. Syringing also has its drawbacks.[1] Evaluating a group of cerumenolytics, including a new British preparation, Hinchcliffe[5] found the latter no better than the others in current use. It was therefore decided to explore the efficacy of a new cerumenolytic for its scope in clinical practice.

Symptoms of Wax Accumulation

A variety of symptoms may bring the distressed patient to the otologist; pain, noises, autophony (like talking into a barrel), occasional giddiness, vertigo, reflex cough and even epileptic attacks have been caused by the presence of hardened cerumen in the auditory canal.[1,3] The most important symptom is deafness. As long as there is a small aperture in the wax, this disability will be absent. The sudden onset of deafness, however, is in itself diagnostic. The sudden movement of wax may completely occlude the passage. Another common occurrence is the onset of deafness after bathing or washing the ear, which causes the wax to swell and completely block the passage.[2] When the canal is closed or the plug falls against the tympanic membrane, the patient will complain of a sense of fulness and deafness.[3]

Etiology

Accumulation of wax varies greatly in different persons, but is more commonly found in those engaged in certain occupations such as mining, and fire fighting, and in dust-producing industries.[2] There seems to be an overabundant secretion of cerumen in persons affected with acne and seborrhea of the face.

Anything which prevents the cerumen from coming out of the orifice, such as atresia of the canal, constriction from swollen tissues or body growths, or numerous hairs about the tragus, will act as a cause.[3] Frequently patients, while cleansing the ear, attempt to dry the canal with the end of a towel, thus pushing the mixed cerumen and soap farther in. Once it begins to accumulate, a plug is formed rapidly. In aged persons, the external meatus becomes flattened, so that cerumen is more likely to accumulate.

In some instances accumulation may be due to a scaly condition of the walls of the canal, which prevents the cerumen from escaping as it should. Whatever the precipitating cause, age is not a differentiating factor.

Diagnosis

While impairment of hearing is more constantly associated with otitis media,[6] the possibility of otitis externa[7] must not be excluded when there is blocking of the canal. Loss of hearing will be proportional to the degree of obstruction.

Frequently diagnosis can be made with the naked eye if the auricle is pulled upward and backward. After introduction of a speculum with a light reflected from the head mirror, a yellow or brownish mass or masses will be seen, and by touching the mass with a probe a diagnosis of cerumen plug can usually be made. To avoid error in diagnosis when numerous stiff hairs are covered with cerumen, it is necessary to push the speculum beyond these hairs.

Sometimes a foreign body smeared over with cerumen may be mistaken for a plug, or the canal may be filled with dry cholesteatomatous masses. Tests made with tuning forks will show increased bone conduction on the affected side unless the inner ear is involved.[3] Expulsion of ceruminous masses on syringing the ear confirms the diagnosis.[1]

From the Department of Medicine, University of Miami School of Medicine.

Clinical Effects of Impacted Wax

Whatever prophylactic effect earwax possesses, if it is not naturally expelled from the ear along with accumulated dust and cellular debris, a plug may form and become gradually hard, dry and adherent to the epithelial lining of the canal.

The advanced condition of accumulation of wax—keratosis of the ear—consists of gradually increasing pressure on the epithelial lining with consequent desquamation. New epithelium is formed, and new wax is deposited within the mass. The end result of this pressure is that the external bony canal is enlarged to such an extent that it becomes impossible to remove the wax without an anesthetic.

Erosion of bone may be such that facial paralysis will result; it has been recorded as occurring by reason of the extensive bony destruction. This should always be kept in mind when it is found difficult to remove a mass of wax.[2]

Senturia and Liebmann[10] warned against ". . . piling up of old debris and wax in the ear canal [which] macerates and irritates the skin and makes it more susceptible to disease. Right now in the hot, humid St. Louis weather, we are seeing a large number of patients with infected ear canals as a result of impacted wax and secondary infection."

Seltzer[11] pointed to a special hazard to swimmers who have wax, especially in one ear. If one ear is obstructed by wax, the swimmer experiences the vertigo associated with the caloric test when the cold water enters the ear. The vertigo is frequently accompanied by panic of the swimmer leading to drowning. "The conclusion is clear that all swimmers should make sure that they do not have wax in their ears—particularly in one ear only—before going into the water."

The other effects—itching, pain, sense of fulness, autophony, deafness and a persistent dry cough from irritation of the tympanic branch of the vagus[1]—are well known.

Management

Treatment consists of removal of the wax. The technic is comparatively simple, provided care and gentleness are exercised. It can be removed safely by picking it out, but syringing is the more usual method.

If the wax is hard, it has to be softened by instillation of saturated solution of sodium bicarbonate two or three times daily before removal. If syringing has little effect, a wax curette or probe is used to make a little opening along the posterior wall behind the wax. Care should be taken to avoid a direct jet against the drum membrane. Olive oil and hydrogen peroxide have been used as softeners, but Senturia[4] cautioned against the latter: "One important form of irritation not to be overlooked is that which follows the use of hydrogen peroxide to remove impacted cerumen. Since an aqueous preparation may cause maceration of the skin of the ear canal, irrigation . . . with peroxide or water should not be performed indiscriminately."

None of the substances used as cerumenolytics is entirely satisfactory. Olive oil is not miscible with water. Hydrogen peroxide breaks up the mass, but may cause pain because of swelling of the plug. Both hydrogen peroxide and glycerin preparations may cause a dermatitis.

A New Approach to Cerumenolysis

A cerumenolytic (Cerumenex) recently made available was formulated on the basis of the chemical composition of cerumen. Its active principle is a surface active agent*—a fatty acid condensate of a protein polypeptide with the formula:

$$C_{17}H_{23}CO.\ HN\ (CHR.\ CO.\ NH)_n\ CHR.\ COOMe$$

Propylene glycol, a viscous, nonvolatile, aqueous-miscible vehicle is the carrier for the surface active agent. Chlorobutanol (0.5 per cent) is added as an antibacterial preservative.

The pH of Cerumenex is approximately pH6, and the surface tension is below 35 dynes per centimeter,[2] which favors its penetration and disintegration of the ceruminous plaque. It has a low "irritation index" based on the rabbit eye irritation test.

Cerumenex was employed in a clinical study of 45 patients suffering from excessive accumulation of earwax. Excellent results were reported with only one application (5 to 6 drops), the period of contact of the drug with the ear tissue averaging 15 minutes.

Material and Methods

The patients, 21 female and 24 male, ranged in age from three months to 83 years. None had had an aural pathologic condition prior to the use of Cerumenex. Nineteen had excessive accumulation of earwax, 20 moderate accumulation and six above normal accumulation. In 40 of the patients the cerumen obstructed the ear drum, and in 28 the cerumen was hard and dry. Twenty-

* Cerapon Brand of triethanolamine polypeptide oleate-condensate.

Table 1.—Response to Cerumenex

Degree of Impaction					Effect			Comments
	4 +	3 +	2 +	1 +	Excellent	Good	Poor	
Number of patients	25	5	5	10	38 (84.4%)	3 (6.7%)	4 (8.9%)	No side effects

Note: 4+ obscures tympanum; 3+ hard, dry; 2+ excessive wax; and 1+ moderate

three had bilateral impaction and 22 a unilateral condition. None had a punctured ear drum.

The technic employed was one application lasting between 15 and 30 minutes either in the office or at home. The ear was plugged with cotton. Warm water irrigation was used subsequent to the application of the drug.

Results

The response to the drug was excellent. The response was graded as: excellent (complete removal of wax); good (partial removal); and poor (little or no activity). Excellent results were obtained in 38 or 84.5 per cent of the cases, good results in three or 6.5 percent, and poor results in four or 9.0 per cent (table 1).

There was no correlation between the degree of impaction and cerumenolysis, excellent results being obtained in all but one of the 4 plus cases, those in which the tympanum was obscured.

Tolerance and Acceptance

No side effects were noted, there being no irritation, inflammation, pain, itching, contact dermatitis or other untoward reaction. The technic employed was readily accepted by the patient.

Summary and Conclusions

Excessive accumulation of wax and impaction in the external ear have long been a vexing problem in otologic practice. The effects include pain, itching, irritation, tinnitus, vertigo and deafness. Treatment with numerous wax softeners and syringing has been unsatisfactory.

In a clinical study of 45 patients ranging in age from three months to 83 years a new cerumenolytic proved effective. Containing a surface active agent, Cerumenex is formulated to penetrate and disintegrate the ceruminous plaque. Tested by the rabbit eye irritation criterion, it was found to have a low "irritation index."

Cerumenex is a safe, effective cerumenolytic, giving excellent results in patients with hard, dry, impacted earwax. A single application in the office or at home will dissolve the wax without irritation, pain, itching or other side effects. It is easily applied and meets with patient acceptance.

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A New Anti-Inflammatory Topical Steroid

A Comparative Study

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Since the demonstration of the anti-inflammatory properties of topical hydrocortisone,[1-3] there has been a constant endeavor to develop newer and more powerful anti-inflammatory agents. In recent years the anti-inflammatory properties of such newer topical steroids as prednisolone and fluoro-hydrocortisone have been evaluated and attested as to their effectiveness.[4,5]

The purpose of this report is to evaluate clinically the topical anti-inflammatory properties of a new synthetic corticoid, the acetonide of 9-alpha-fluoro- 16 -alpha-hydroxy-prednisolone (triamcinolone) by comparing it with hydrocortisone. According to Fried and his associates,[6] triamcinolone acetonide exhibited 40 times the anti-inflammatory activity of hydrocortisone acetate.

Material and Methods

In this study 0.1 per cent triamcinolone acetonide (Kenalog*) was compared locally with a 1.0 per cent hydrocortisone preparation. A double blind technic was employed with the exact nature of the preparations being unknown to both the patient and the investigator. A paired comparative study was utilized when feasible with the patient applying the triamcinolone acetonide to the involved area and the hydrocortisone to a similarly involved contralateral area. Where contralateral areas could not be compared, medications were alternated to obtain a comparative study. Fifty patients with various skin disorders were evaluated in this study. In 30 patients 0.1 per cent triamcinolone acetonide lotion was compared with a 1.0 per cent hydrocortisone lotion, and in 20 patients 0.1 per cent triamcinolone acetonide cream was compared with 1.0 per cent hydrocortisone cream. The cases studied were essentially limited in type to those in which there had been some therapeutic response to hydrocortisone. In almost all instances the patients were able to be observed at one to two week intervals.

Results

Table 1 summarizes the different skin conditions treated, the number of patients, and the comparative response obtained.

Table 1.—Comparative Results Obtained

Diagnosis	Number of Patients	Triamcinolone Better Than Hydrocortisone	Triamcinolone Equal to Hydrocortisone	Hydrocortisone Better Than Triamcinolone
Chronic dermatitis of hands or feet	17	10	5	2
Chronic eczematous dermatitis	15	10	4	1
Atopic dermatitis	3	2	1	—
Acute contact dermatitis	4	1	3	—
Seborrheic dermatitis	5	3	2	—
Lichen simplex chronicus (circumscribed neurodermatitis)	6	6	—	—
Total	50	32	15	3

Discussion

In 64 per cent of the cases it was found that triamcinolone acetonide was superior to hydrocortisone. In 30 per cent of the cases triamcinolone acetonide was equal to hydrocortisone. It must be remembered, however, that certain skin conditions such as the acute contact dermatitides resolve quickly under any anti-inflammatory therapy. A superior anti-inflammatory agent, therefore, would not be readily discernible in these conditions since such cases would also clear quickly under weaker anti-inflammatory agents. The results, accordingly, must be interpreted with these factors in mind. On the other hand, in the chronic therapeutically refractory conditions such as lichen simplex chronicus (circumscribed neurodermatitis) the superior anti-inflammatory properties of the triamcinolone preparations were most clearly apparent. Three of the six patients with lichen simplex chronicus, all of whom gave a many year history of this condition and upon whom multiple topical steroid preparations had been previously used, for the first time showed complete resolution of their eruption.

One patient complained of a burning sensation with the triamcinolone lotion, but tolerated the cream with an effective therapeutic response. It was assumed, therefore, that this patient showed

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*Triamcinolone acetonide was supplied as Kenalog through the courtesy of The Squibb Institute for Medical Research, New Brunswick, N. J.

an intolerance to the vehicle rather than the active agent. In no case was there any clinical evidence of adverse systemic effects produced by topical application of triamcinolone acetonide.

Summary

A clinical study comparing the topical effects of 0.1 per cent triamcinolone acetonide, a new synthetic corticoid, with 1.0 per cent hydrocortisone on various dermatologic conditions was undertaken. A series of 50 patients was evaluated. Triamcinolone acetonide exhibited superior anti-inflammatory activity in 64 per cent of the cases. The superior anti-inflammatory effects were most clearly evident in the chronic therapeutically refractory skin conditions.

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Localized Diathermy in the Treatment Of Traumatic Hyphemia

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The occurrence of bleeding in the anterior chamber after contusion of the bulbus oculi can present, on occasion, an intractable condition with ultimate loss of the eye. Observation of the mechanics of bleeding related to the apparent lesion has led me to a concept that, I believe, is particularly in keeping with the disturbed physiology. As representative of a group of patients, there is offered a series of five cases which demonstrate the management of traumatic hyphemia with localized diathermy.

The anterior ciliary arteries have connections with the episcleral limbus plexus and the anterior conjunctival arteries which terminate in the ciliary body, major circle of the iris and anterior choroidal vessels. These vessels are vulnerable in any blow of low velocity to the bulbus oculi. Frequently, the source of bleeding is a small, localized area which can be detected early. After the anterior chamber has been filled with blood, however, the recognition of the source becomes more difficult. Conceivably, at the time of opening the anterior chamber and attempting to evacuate the collected blood, renewed bleeding from the radial vessels may be recognized. Diathermy has been employed in treating glaucoma,[1] angiomatosis retinae,[2,3] Eales' disease,[4] and Hippel's disease.[5] On the basis of these experiences and reliance on the safety of this procedure, it was decided to use it in one other condition, traumatic hyphemia.

Technic

It is best to subject the patient to anesthesia with intravenous Pentothal sodium. This is fortified with topical application of a 2 per cent solution of Pontocaine. At this time the tension is determined. A retrobulbar injection with a 1 per cent solution of Xylocaine containing epinephrine 1:100,000 is then given. A wet sponge held against the bulbus oculi with slight pressure will diffuse this solution into the muscle cone and decrease the tension. The tension is again determined. Now further inspection of the eye will reveal the source of bleeding and any additional pathologic change that may be present.

As a source of diathermy a Hyfrecator can be used or a Bovie Unit. Any other apparatus that the operator is familiar with will also serve. An indifferent or inactive electrode is attached. Good contact is made by using the ring electrode which is hung from the set screw of the self-retaining eye speculum. The active electrode is a shielded curved electrode exposed at its end for 1.5 mm. This will penetrate the conjunctiva and reach into the outer layers of the sclera. The machine is

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set to run seven seconds by the clock, and current is stepped up by setting the dial at 40 on the Hyfrecator and 15 on the Bovie Unit. A point 6 mm. behind the limit of the chamber angle is selected, and the imagined artery, for it cannot be seen, is straddled with four puncture points. If bleeding occurs in the next 24 hours, the vessel has been missed, or there is a further pathologic condition not amendable to localized diathermy.

Report of Cases

Case 1.—A man, aged 35 years, while chasing a pig, was struck in the left eye by a branch of a bush. He had pain in the eye, slight reduction of vision, and slight subconjunctival hemorrhage. There was slight hyphemia with fluid level. On leaning the patient face down and looking at the cornea, it was observed that while the greater mass of blood was displaced to the center of the cornea, there was a persistent strand of blood from the 6 o'clock position. It was thought that this position was the origin of the bleeding and that a radial vessel of the iris was involved.

Accordingly, a 2 per cent solution of Pontocaine was instilled into the eye, and with the patient in the recumbent position a retrobulbar injection of a 2 per cent solution of procaine containing epinephrine 1:100,000 was given. There was good anesthesia and akinesia. The tension decreased from 40 mm. Schiotz to 16 mm. An electrode such as is used for cyclodiathermy for glaucoma was attached to a Hyfrecator apparatus, and an indifferent electrode attached the self-retaining lid speculum to the other lead of the machine. This particular machine was set at 40 on the dial. Four intrascleral points located 7 mm. behind the limbus at the 6 o'clock position were then coagulated for seven seconds by the clock. There was no further recurrence of bleeding. Three weeks later the tension was 20 mm. Schiotz and the uncorrected vision was 20/15. This result left the impression that a method that seeks out the origin of the bleeding from the vessels that cross the iris root and then seals them using localized diathermy would offer the ophthalmologist a secure tool in controlling hyphemia.

Case 2.—A schoolboy, aged 16 years, was struck in the right eye when a companion threw a small hard unidentified object. There was pain in the eye and photophobia; vision could not be properly recorded. After instillation of a 0.5 per cent solution of Pontocaine, it was apparent that there was a small superficial abrasion of the corneal epithelium which stained with fluorescein in a 2 per cent solution. The pupil was 3 mm. wide and slightly flattened at the 8 o'clock position. Tension was 30 mm. Schiotz.

The patient was admitted to the Orange Memorial Hospital. Under anesthesia induced by intravenous Pentothal sodium, a 2 per cent solution of Pontocaine was instilled into the right eye, and a retrobulbar injection of 1.5 cc. of Xylocaine in a 1 per cent solution containing epinephrine 1:100,000 was given. The tension decreased to 14 mm. Schiotz. Localized diathermy was performed as in case 1, paralleling the limbus at the 7 to 8 o'clock position. During the course of the next seven days there was no further bleeding, and the tension was 19 mm. Schiotz. Vision was 20/20 uncorrected on the fourteenth day.

Case 3.—A man, aged 50 years, was struck in the left eye, during an altercation, with the heel of a lady's shoe. The blow came from above downward. It struck the left eye at the 12 o'clock position and everted the lower lid, tearing a very small notch from the border of the lid. At the 8 o'clock position there was a small pear-shaped mass of blood hanging downward. The pupil was flattened at the 12 o'clock position and measured 4 mm. as compared to 2 mm. in the right eye. It was thought that the source of the bleeding could only be from the 8 o'clock position.

The patient was hospitalized at the Orange Memorial Hospital. Under anesthesia induced by intravenous Pentothal sodium, a 2 per cent solution of Pontocaine was instilled into the left eye. A retrobulbar injection of 1.5 cc. of Xylocaine in a 1 per cent solution containing epinephrine 1:100,000 was given. The tension decreased from 36 mm. Schiotz to 19 mm. It was now apparent, however, that the pear-shaped mass of blood had increased to about twice its size. A keratome incision was made at the 8 o'clock position, and with a wet cotton wipe, the blood clot was evacuated. This procedure was followed by localized diathermy 7 mm. behind the limbus at the 8 o'clock position. A 6-0 black silk suture was used to close the wound.

In 24 hours, re-examination revealed that the bleeding had not subsided and the anterior chamber again held blood. It was now noted that the strands of blood were from the 12 o'clock position. The procedure was again repeated in the operating room with the additional localized diathermy at the 12 o'clock position. The patient made an uneventful recovery. The uncorrected vision at the end of three weeks was 20/20, and the tension was 20 mm. Schiotz.

Case 4.—A schoolboy was struck in the left eye during a football scrimmage. His opponent struck him with the extended finger of the left hand. The point of impact was apparently located nasally, producing a small subconjunctival hemorrhage at 9 o'clock. When seen in the emergency room of the Orange Memorial Hospital, he complained of pain, photophobia, and reduction of vision. Vision in the left eye was only hand movements. There was corneal edema, and definite, although slight, hyphemia.

Under anesthesia induced by intravenous Pentothal sodium, a 2 per cent solution of Pontocaine was instilled into the left eye, and 1.5 cc. of a 1 per cent solution of Xylocaine containing epinephrine 1:100,000 was injected retrobulbarly. The tension decreased from 50 mm. Schiotz to 22 mm. At the 9 o'clock position, 7 mm. behind the limbus, a localized diathermy was performed in three places. There was no further increase in bleeding. In the course of the next seven days there was no further bleeding. At the end of three weeks there was no further bleeding, and the uncorrected vision was 20/20, the tension being 20 mm. Schiotz.

Case 5.—An 11 year old boy tried to protect his younger brother from maternal chastisement, when he received the full impact of a strap lash across the left eye. Three hours later, some redness and edema of the lids, slight subconjunctival hemorrhage, and a thin ooze of blood from the 9 o'clock position downward toward six o'clock in the anterior chamber were observed. There was photophobia, with no elevation of tension on finger palpation and no apparent edema of the cornea.

The patient was admitted to the Orange Memorial Hospital. He was anesthetized with a 2 per cent solution of Pentothal sodium intravenously; a 2 per cent solution of Pontocaine was instilled into the left eye; and a retrobulbar injection of Xylocaine in a 1 per cent solution containing epinephrine 1:100,000 was given. During the setting up of photographic equipment, it became apparent that the bleeding was increasing slowly. At a point 6 mm. behind the limits of the anterior chamber a localized diathermy was performed. Here a 20 gauge hypodermic needle was held with a mosquito clamp, which in turn was touched by the active electrode of the Bovie Unit. The machine had been set at the 15 mark. Two other points at the 7:30 and 6 o'clock positions were also treated as a precaution. Two drops of a 2 per cent solution of homatropine were then instilled into the eye. Recovery was uneventful, there being no further bleeding. The vision was 20/15 uncorrected.

Comment

It is possible to have spontaneous resolution of hyphemia even without medical attention. Unfortunately, this is not to be relied on. In some instances the occurrence of traumatic hyphemia spells disaster for the integrity of the eye. There may be iridodialysis with the iris curling up into a small mass in the periphery of the anterior chamber. There may be separation of the ciliary body, dislocation of the lens, detachment of the retina and laceration of the sclera, as well as corneal injuries. Not all of these are matters to be resolved with localized diathermy, nor is traumatic hyphemia to be thought of as the lesion itself. Hyphemia can only mean vascular bleeding. If the vessel can be influenced by the coagulation current, it is reasonable to expect a control of the bleeding. If subsequent inspection shows that the bleeding has not been controlled and the location has not been accurately defined, the procedure must be repeated with diathermy at a new location. It is hoped that many more eyes will be saved by a procedure that is safe in so far as the eye is concerned, needs no additional armamentarium, and with suitably selected patients can be carried out under local anesthesia.

Summary

Five cases of traumatic hyphemia are described. The method of use of localized diathermy to coagulate bleeding radial vessels of the iris is described.

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The Value of Diiodohydroxyquin In Combination in the Treatment of Trichomonal Vaginitis

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The following is a study of 218 cases of trichomonal vaginitis and 22 cases of monilial infection treated with a compound of diiodohydroxyquin and other agents in which the condition was cleared up in 235 cases, or 98 per cent. In only five cases, or 2 per cent, was this therapy resisted.

A vaginal tablet* of the following composition was used:

Diiodohydroxyquin	100 mg.
Phenylmercuric acetate	3 mg.
Sodium lauryl sulfate	3 mg.
Papain	20 mg.
Potassium aluminum sulfate	14 mg.
Lactose	430 mg.
Dextrose, anhydrous	736 mg.

Two of the vaginal tablets were inserted deep into the posterior vault of the vagina before retiring. To prevent recurrence, this treatment was continued for six to eight weeks.

In my experience, trichomonal vaginitis is the most common of all vaginal infections. It has constituted 80 per cent of the vaginal infections in my practice. As Davis[1] said, "A Trichomonas vaginalis infection should be suspected whenever a woman complains of a vaginal discharge with itching."

Diagnosis

In making the diagnosis of trichomonal vaginitis, it is important to instruct the patient to avoid douching for at least three days prior to her visit to the office. The characteristic discharge consists of thin, yellow and often frothy pus. The vaginal wall is irritated and angry red in color. It may show punctate hemorrhages.

The diagnosis is confirmed by identifying the Trichomonas vaginalis in the vaginal smear, either by the hanging drop method or the Papanicolaou stained smear.

An important part of treatment is to instruct the husband to use condoms during coitus so as to avoid marital reinfection. The prepuce, male urethra, seminal vesicles and prostate are important foci of infection. If condoms are used for from three to nine months and the wife is cured of the disease in the meantime, the micro-organisms will die out in the male genitalia so that there will no longer be danger of reinfecting the wife.[2]

Rationale of This Compound

These vaginal tablets contain seven active ingredients, each of which serves a definite therapeutic purpose in the treatment of trichomonal vaginitis.

1. Diiodohydroxyquin kills the trichomonads.[3-6]
2. Phenylmercuric acetate is a fungicide and additive to diiodohydroxyquin in its trichomonacidal action.[7]
3. Sodium lauryl sulfate breaks into the coating of the trichomonads with an explosive action.[8,9]
4. Papain digests and dissolves the mucoprotein coating of the trichomonads and thus makes them vulnerable to the protozoacidal agents.[10,11]
5. Potassium aluminum sulfate is astringent and reduces the leukorrhea, also acts as an acid buffer.[12]
6. Lactose helps to restore the normal acid hydrogen ion concentration of the vaginal secretion.[13-15]
7. Dextrose promotes growth of Döderlein's bacillus, a normal friendly inhabitant of the vagina which is antagonistic to T. vaginalis.

Therapeutic Procedure

During the office visit the patient is instructed to insert two tablets into the posterior vault of the vagina at bedtime. The thick substance that forms is cleared away by douching with Amfrecin Powder solution each morning before inserting the Baculin vaginal tablets. The husband and wife

*Supplied as Baculin vaginal tablets by Amfre-Grant, Inc., Brooklyn 26, N. Y.

should abstain from intercourse for one week; then the husband should wear a condom for coitus during the treatment period and for at least two months afterwards to avoid reinfection.

Treatments should be used for a period of six to eight weeks. They should be maintained even after the symptoms have subsided and until repeated smears are negative so as to avoid recurrence. The treatments should be continued throughout the menstrual periods, with which they do not interfere in any way.

Results

This method of treatment cleared up the infection in 235 of 240 cases, including 218 of trichomonal vaginitis and 22 of monilial infection. There was complete eradication of the infection within one month in 85 per cent of the cases, in two months in 95 per cent, and in three months in 98 per cent. Failure in 2 per cent may be ascribed partially to lack of cooperation on the part of the patient or her husband.

Karnaky[16] examined over 300 private patients treated with Baculin and found that all were free from infection after only two weeks. The smears became negative for infectious organisms within 24 to 48 hours.

My own experience has confirmed the statement[14] that the treatment stops the itching and burning immediately and also controls the disagreeable odor. This result is accelerated by occasional douching with Amfrecin Powder during the treatment period.

I also agree with Karnaky[14] that no vaginal douche alone will eradicate T. vaginalis from the vagina.

Summary

Trichomonas vaginalis is responsible for about 80 per cent of all vaginal infections.

The condition can be cured in six to eight weeks by the daily use of trichomonacidal vaginal tablets. This treatment does not interfere with the menstrual function and should be continued throughout the periods.

In addition to its direct trichomonacidal action, the compound has other properties which are important in eradication of T. vaginalis.

To avoid reinfection, the husband must use condoms for about two to three months.

As with any other trichomonacidal suppository, occasional but rare irritations of the vaginal mucosa may occur, necessitating change of treatment.

With use of these vaginal tablets in a series of 218 cases of trichomonal vaginitis and 22 cases of monilial infection, the condition was cleared up in 235 cases, or 98 per cent.

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The Unknown Diabetic

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It is a truism that there are large numbers of people who, unknowingly and unwittingly, have diabetes mellitus. The number has been suggested to be as high as one million. For this reason, since the first national Diabetes Detection Drive in December 1948, there has been a concerted effort on the part of organizations like the American Diabetes Association and the various Public Health organizations to detect the unknown diabetic.

The practicing physician also, I am sure, considers himself in the forefront of the battle to find the unknown diabetic. He does so because he usually requires that a urinalysis be performed on every patient he sees. He also usually considers that his duty has been done, as far as determining whether his patient has asymptomatic diabetes, when he performs the urinalysis. As a result, many physicians have discovered, to their chagrin, that not infrequently patients they have been following for some years, who have been asymptomatic and who have had at least one urinalysis performed, if not more, are suddenly discovered to have diabetes mellitus. The diabetes sometimes may be comparatively far advanced, and its presence at times explains previously inexplicable symptoms. Such a situation redounds neither to the credit of the physician who has been taking care of the patient, nor to the benefit of the patient.

For this reason, my associates and I urge that the search for the unknown diabetic be pursued as vigorously in the doctor's office as it is, perhaps, as a public health measure, and that the physician not rely on examination of a casual urine, which is most often obtained with the patient fasting, as the sole means of determining which ones of his patients have symptomless diabetes.

In a previous paper we urged the use of the two hour after meal urine test as a means of detecting diabetes.[1] We noted therein that approximately 5 per cent of the patients whose casual urine showed no glycosuria were diabetics. That is, of all of our patients with negative results on examination of casual urine, on checking the urine two hours after a high carbohydrate meal, approximately one out of each 200 had true diabetes—symptomless, it was true, but nevertheless true diabetes. We also noted that some of these patients had been followed by us for some years; repeated urinalyses had been performed, but diabetes had not been discovered.

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Tests Evaluated

We have found that this test is simple and apparently adequate. Nevertheless, we thought that we should check further into the possibility that other simple technics might be used to find those diabetics, perhaps, who would not be found even in using the postprandial urine test. Among the most commonly used of these technics is the determination of the blood sugar level after a high carbohydrate meal or after a standard dose of 100 Gm. of glucose. It has been found that when comparison of the blood sugar and urine examinations has been used for the detection of diabetes, the blood sugar determinations are, in general, more sensitive. After an adequate meal containing at least 25 Gm. of sugar, Harting and Glenn[2] found that in 2.2 per cent of 3,186 tests the results were positive, and that, utilizing urine tests after a high carbohydrate meal, or a blood sugar test after a high carbohydrate meal, blood sugar tests were 50 per cent more sensitive than the urine tests. This difference was especially true in mild diabetes. It was also noted by Engelhart, Greene and Baird,[3] who likewise observed that utilization of the blood sugar provided a more sensitive test.

Since we had used the high carbohydrate meal with previous dietary preparation to determine the presence of postprandial glycosuria, we decided to check the relative merits of determining the blood glucose level two hours after a high carbohydrate meal and two hours after ingestion of 100 mg. of glucose. We used as standards of

reference 130 mg. per hundred cubic centimeters, employing the Folin-Wu technic, as the top normal, from 130 to 160 mg. as presumptive diabetes, and above 160 mg. as true diabetes. It is true that the relationship of the fasting blood sugar level to the two hour sugar level, and the height of the peak, are significant. It is our belief, however, that the height of the blood sugar level after two hours had the greater significance, and such a determination was simpler and less costly and time-consuming for the physician and the outpatient for routine use.

In 72 ostensibly normal patients, who were given a high carbohydrate meal on one occasion and 100 Gm. of glucose on another, we found that there was no consistent difference in the level of the two hour test; that, of 72 in whom the level was below 130 mg., it was higher after the meal in 17 and in 19 after the ingestion of glucose. This lack of difference, however, was not true in those patients, also ostensibly normal, in whom the blood sugar level was above 130 mg. and who, therefore, had presumptive or true diabetes. Twenty patients, who had no evidence of diabetes, and in whom urinalysis gave negative results two hours after a high carbohydrate meal, had a blood sugar level above 130 mg. after one of the two tests. Of this group of 20, two only had a blood sugar level above 130 mg. after the meal, but 18 had such a level after the ingestion of glucose.

Table 1. — Positive Blood Sugar Determinations After 100 Gm. of Glucose and a High Carbohydrate Meal, in the Presence of Normal Urine.

Positive after glucose	18
Positive after meal	2
Total	20

There were 24 patients whose fasting urine was normal, but who had glycosuria after a high carbohydrate meal or after ingestion of glucose; two had a blood sugar level over 130 mg. after the meal alone; 12 had a blood sugar level over 130 mg. after ingestion of the glucose alone; 10 had a blood sugar level over 130 mg. both after the meal and after ingestion of the glucose.

Table 2. — Positive Blood Sugar Determinations After 100 Gm. of Glucose and a High Carbohydrate Meal, in the Presence of Postprandial Glycosuria

Positive after glucose alone	12
Positive after meal alone	2
Positive after both	10
Total	24

Of the 20 patients with normal urine both before and after meals, 15 had a blood sugar level between 130 and 160 mg.; five had a blood sugar level between 160 and 200 mg.

Table 3. — Elevated Blood Glucose Levels with Normal Urine

130-160	15
160-200	5
Total	20

These findings are in contrast to those in patients who had glycosuria after a high carbohydrate meal. Of these, in five the blood glucose level was between 130 and 160 mg., in 13 between 160 and 200 mg., in six above 200 mg., and in one above 300 mg.

Table 4. — Elevated Blood Glucose Levels with Glycosuria

130-160	5
160-200	13
Above 200	6
Above 300	1
Total	25

Discussion

Two conclusions seem warranted. There is no great difference in utilizing the meal or the standard one dose of 100 Gm. of glucose in patients whose carbohydrate tolerance is normal since the blood glucose level after a high carbohydrate meal or after ingestion of 100 Gm. of glucose is approximately the same. There is no doubt, however, that in the patients who have diminished tolerance, the standard one dose of 100 Gm. of glucose is more effective, and will, at times, apparently reveal decreased glucose tolerance, which may not be found after a high carbohydrate meal. The fact that glucose is more effective than a high carbohydrate meal has also been reported by others.[4]

It would appear from our findings, as limited as the numbers involved are, that decreased glucose tolerance to the extent of the presence of true diabetes may exist in the absence of postprandial and postglucose glycosuria. The extent of the decrease in tolerance, however, is in general much less than when examination of the postprandial and postglucose urine gives a positive result. In general, the standard one dose glucose test gives a higher percentage of positive results in blood tests, whether the urine shows a positive reaction or not.

The next question that comes to mind is: How significant are these findings? Are they

comparatively unimportant temporary diminutions in carbohydrate tolerance, or do they carry significance as to the presence of diabetes? Previous investigations on persons with apparently minimal evidence of decrease in carbohydrate tolerance show that in a high proportion of them diabetes develops. Rabinowitch[5] showed that in a 10 year follow-up of patients whose sole abnormality was a single episode of asymptomatic glycosuria, diabetes developed in 29 per cent, even though the glucose tolerance test gave normal results at the time of the asymptomatic glycosuria. If the peak of the glucose tolerance test was abnormal, the incidence of true diabetes was 40 per cent. He recommended that a patient with glycosuria should be considered a potential diabetic and so treated.

Wilkerson and Krall[6] used 200 mg. some time after eating as their standard in differentiating between the normal and abnormal. Of those patients whose blood sugar was between 170 and 200 mg., and who were therefore presumably normal, true diabetes developed in 31 per cent in a short four year period of follow-up.

In view of these findings, there is no doubt that any abnormality of carbohydrate tolerance is extremely suggestive and does require follow-up. Examination of the postprandial urine is a most effective simple screening technic. It would be more effective if glucose were used instead of the meal. It, however, would then lose its facility in application as a simple screening technic.

When the blood sugar value can be obtained, its determination two hours after the administration of 100 Gm. of glucose gives the simplest and most effective method for the discovery of the unknown diabetic.

Summary

The use of the postprandial urine test is discussed. The relative merits of the blood sugar determination after a high carbohydrate meal and after administration of the standard 100 Gm. of glucose in the discovery of the unknown diabetic are evaluated. The conclusion is drawn that the simplest technic is the determination of blood sugar two hours after administration of 100 Gm. of glucose.

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601 South Federal Highway.



Working Together

JERE W. ANNIS, M.D.
LAKELAND

First of all, let me express my appreciation for the opportunity of being here in Miami and talking with you briefly on the general theme of "Working Together." Our two great professions have one and only one basic objective—the best possible care of sick people. Whatever other motives may affect or activate us in our work, they are all secondary to this one basic and underlying purpose. Certainly no group affects more directly or more materially the physician's fulfillment of this obligation to his patient than does yours. By working with us daily, by sharing our professional successes and failures, by helping us meet our problems and continue the task to which we are dedicated, you come to know more about us than we know about ourselves. You come to be closer to us in a professional capacity than any other person. Yours, then, is the privilege, if you will, but certainly the duty and the responsibility of being the doctor's alter ego, of representing him to his patients and to the public. No association can be closer than this, nor depend more for success on the complete cooperation of the persons involved.

The importance of working together, and in doing so harmoniously, cannot possibly be of any greater importance to anyone than it is to you and your doctor. Modern Medicine, with its increased technological skills, its rapid advances and startling new scientific achievements, demands, as never before, that the physician have ever available a competent and efficient technical assistant, as well as a pleasant and capable public relations representative. You are asked to fill this dual role, and to do so adequately will require much time, effort, study and conscientious devotion to an arduous task.

Nursing, like medicine, is no longer a simple, uncomplicated profession in which the patient and sympathetic approach to problems of hardship, pain and disease is sufficient to qualify the practitioner as professionally adequate. Today, both you and I are rightfully expected by an educated public to provide pleasantly not only dedicated service and advice, but also the highly specialized and technical skill and knowledge which modern science has developed. To accomplish this objective in a creditable manner requires a spirit of confidence, trust and devotion on the part of each of us.

There is, of course, more to this problem of working together, in its broad sense, than just the cooperation between doctor and nurse. There is the all-important field of close cooperation and harmony between you yourselves as Registered Nurses. In this broad area you act as the professional or administrative assistant to the physician. Your duties are many and varied—just as are your responsibilities—and they involve many variegated facets of technological skill, executive responsibility, and nursing acumen. You are called upon to fill many and different places on the modern medical team. It is vitally important that, if this team is to function well, your relationships with your professional counterparts—be they in the same echelon as yours or the one immediately above or below it—be of the highest order. It is of similar importance that your public relations and your cooperation with those whom you are called upon to direct and instruct be equally satisfactory. I refer here to the Licensed Practical Nurses, the aides, the orderlies, and the many others who come under your direct supervision. As I have mentioned before, Medicine today moves forward through the effectiveness of team effort, and its outstanding achievements can be accomplished only through team spirit and cooperation.

Nursing goes back to the dawn of history, to the creation of man, and like Medicine, it demands from its disciples a constancy, a devotion, and a dedication which set them apart from those of most other professions. Such dedication transcends all national, family, racial and religious boundaries, and gives rise to a universal language and understanding. All this is your heritage, and all this must be protected most jealously from the assault of a public opinion which often, through ignorance, would classify your calling as a "trade" or a "business." Yours is a *fine* heritage—be true to it.

President of the Florida Medical Association.
Presented before the Florida Nurses Association Convention, Office Nurses Section, Miami, Oct. 16, 1958.

Tolstoy has written that the vocation of every man and woman is to serve other people. This is particularly true of your profession, and is, in itself, another example of the spirit of working together—working together with the persons whom you serve daily in your lives: the patients to whom you are dedicated, if not always devoted. A great and essential ability, indeed a necessary attribute of any who would call herself Nurse, is that she be able and willing courteously, gently and kindly to give of herself to those unfortunates who are ill, whoever they may be. It is a part of your job, your training and your education, to do all this in an unselfish manner, understanding and forgiving the shortcomings of those whom you serve. In your dealings with them you have the advantage of the medical experience and wisdom of the ages to help with the solution of their problems; and since, as Tryon Edwards has said, "the great end of education is, to discipline rather than to furnish the mind; to train it through the use of its own powers, rather than fill it with the accumulation of others," your education and training have qualified you, or should have qualified you, to meet these medical problems in a direct and intelligent manner best able satisfactorily to solve them.

One has but to glance around in the field of Medicine and examine almost any of the great accomplishments which have been made during the present century, or even during the past 10 years, to realize that almost invariably these accomplishments are the work of not one man but of many, that they are indeed the bundling together of innumerable advances and experiments made by literally hundreds of separate individuals, revised and improved and finally put together into a practicable, applicable and effective boon to all mankind. Into this category falls the discovery of insulin. Inasmuch as the final, definitive work of Banting and Best was based upon a foundation of factual data accumulated by literally hundreds of investigators all over the world who worked together and communicated freely with each other, so therefore was this momentous and historic discovery, together with its practical life-saving application, the result of team effort—cooperation. Each research worker knows this reciprocal relationship and realizes his dependence upon his fellow workers, both past and contemporary. Each physician also realizes it and knows that if he is to succeed in carrying out the most effective medical service of which he is capable by training and experience, he must avail himself of all the ancillary services, the co-workers, the technicians, that are a part of the medical team. This, then, if you will, is a clinic type of approach by which better medicine can be purveyed to the public in a more acceptable and economic manner.

Outside our own field we have only to turn our eyes north along the east coast of Florida to Cape Canaveral to appreciate again the importance of working together, of cooperation—of the integration of literally thousands of people, each with a different skill, a different contribution, a different part to play—in the great cooperative effort that culminates in the launching of a mighty missile into outer space. Here again is the visual evidence of the power of cooperation—the strength of unity—and the unlimited achievement which is possible if we apply ourselves carefully to the task of working together. This same team—this same ideal and philosophy of life—has been the guiding spirit among the great political philosophers of our age who have realized that the ultimate success and even survival of mankind itself, and certainly of our Western Civilization, depends to a large extent on our ability to talk logically with, understand and compromise with, learn from and teach, and finally live with in a neighborly fashion, the other nations and the other peoples on this shrinking globe.

Yes, indeed, working together is a basic philosophic principle, as important to the effective performance of the family unit as it is to the world at large, and to your profession and mine. Of course, the factors that make for effective cooperation, or working together, are those fundamentally important traits which we must find within ourselves, and which eventually allow us to work together with others and to contribute our fair share in the cooperative effort. These traits are the basic characteristics inherent in all human beings, but, unfortunately, characteristics which, over the years, we often suppress or relegate to secondary positions for somewhat selfish motives. They are the basic love of one's fellow man—the true spirit of altruism—the respect of one's obligations—a deep sense of integrity and forthrightness—and a sincere and honest desire to improve ourselves and improve our surroundings, as well as the ability critically to evaluate our proper role in a total picture, and to put the interests of others above our own.

These are the basic requirements for cooperation. By evaluating ourselves in respect to them,

and by doing our best to develop them, we can make our effectiveness ever so much greater, and we can collectively accomplish a great deal more. Let us make an honest and sincere effort in this regard. Too, let us remember that what, in a single individual, amounts to coordination—which it is essential that one study and master before he can effectively walk, run, eat, or carry out any other simple maneuver — amounts in several individuals to cooperation, so that the combined efforts of several physical systems may produce a smoothly functioning, unified whole—a team. In a small group such cooperation may be a luxury. In a large group it is certainly a necessity without which the group cannot survive.

In the medical clinic of which I am a part there are some 76 of us—doctors, nurses, technicians, secretaries, bookkeepers, and others. It is, I am sure, obvious to you all that without excellent coordination—without give and take—without the subordination of one's own individual interests on many occasions to the larger interest of the group—utter chaos would result. Because of the need for these attributes, one's ability to cooperate effectively and intelligently is a major factor in deciding whether a given applicant should or should not join the group.

Let me say right here that, while I think this subject is of vital importance to all of us, it was not of my own choosing, nor did I think that you as a group needed to be reminded of it. Indeed, I believe that the members of your profession are better advocates of all the things I have been talking about this afternoon than those of any other profession with which I am acquainted. Nevertheless, the subject is tremendously important to all of us; and so, pray continue to employ your cooperative effort in working with us, and with the others with whom you are associated. I have a little sign in my office to remind me of the value of working together. It reads, "No one of us is as smart as all of us." If you and I keep this in mind, we will accomplish the one thing which is more important to each of us than anything else in the world—to supply our patients with the best possible medical care. Goethe said, "Life is the childhood of our immortality." Let us then live together in harmony like good children.

It has been a real pleasure to come here this afternoon to be with a group that I admire, respect and love so much—and upon whom I am so dependent.

Thank you for inviting me—the best of luck —and God bless you.



ABSTRACTS

Recurring Nasal Polyposis: A Rational Procedure for Its Prevention. By A. R. Hollender, M.D. A. M. A. Arch. Otolaryng. 67:515-520 (May) 1958.

The problem of nasal polyps is elementary, but its ramifications are numerous, and at times complicated. This author concludes that recurrent nasal polyposis is not beyond control by available methods, that the role of allergy in nasal polyposis cannot be disregarded despite the failure of allergic management, and that sufficient attention has not been paid to the interplay of several factors in the etiopathogenesis of nasal polyps. Although the influence of corticosteroids on nasal polyposis is strictly palliative, he regards them as an effective weapon in dealing temporarily with critical situations. He offers a definite plan of therapy which consists of meticulous excision of the polypoid growths, as practiced in the hospital, and postoperative radium irradiation, and reports a high percentage of successful results in preventing recurrence. The most important causes of failure he lists as an indifferent attitude of the rhinologist in following a methodical plan, resort to the office piecemeal technic, failure to cure infection before excision is attempted, and dependence solely on operative extirpation.

Aspects of Pediatric Residency Training. By Robert B. Lawson, M.D. J. A. M. A. 167:200-202 (May 10) 1958.

Since the importance of health supervision is emphasized more in pediatrics than in the other special fields, an ideal graduate pediatric training program recognizes two main areas: (1) treatment of the ill child and (2) guidance of the physical and mental health of the well child. From this approach, Dr. Lawson discusses the changing aspects of pediatrics and, in the light of these changes, the availability of patients and the training experience. In summary, he observes that while all of the specialty fields share some of the same problems, pediatrics is in a slightly better position than many of the other fields since there has not been as striking a shift in the service to private category. Where it has occurred, the judicious use of agency and private patients for teaching has been well accepted. There is a more fundamental shift in the types of illnesses in many of the referral type of teaching centers. An imaginative use of available extramural facilities, however, can make up for any deficiencies in types of clinical material and, in addition, will give the residents valuable experience with patients more closely approaching the type of patients he will have in his own practice.

Torsion of the Appendix Testis. By Raymond J. Fitzpatrick. J. Urol. 79:521-526 (March) 1958.

Four cases of torsion of testicular appendages are presented, bringing the total number reported to 141. Three of the cases demonstrate the relative benignity of torsion of the appendix testis in comparison with torsion of the spermatic cord. Case 2 is unusual in that it is the first reported case of torsion of an appendix testis simultaneously occurring with ipsilateral torsion of the spermatic cord. If the condition is kept in mind, in adults as well as in children, in the differential diagnosis of scrotal pain, if careful attention is paid to the chronologic course of events and careful palpation made, the correct diagnosis will more often be made in this otherwise neglected clinical entity. If the assumption is correct that many cases are being misdiagnosed, it would suggest that ultimate resolution without surgical intervention must frequently take place. Early surgery, however, is still advocated by most authors to reduce a subsequent period of disability by obviating secondary complications. Since the appendix testis serves no useful purpose, the author suggests that it would seem wise to excise all pedunculated testicular appendages during any scrotal surgery.

Mesenteric Thrombosis Complicating Occlusive Disease of the Abdominal Aorta: Case Report. By Samuel M. Day, M.D. and John H. Terry, M.D. Am. Surgeon 24:315-318 (April) 1958.

Acquired diseases of the aorta, occlusions and aneurysms, have been more widely recognized in the past few years. As specific occlusions of major vessels are diagnosed with increasing accuracy and frequency, the error of classifying cases of this

type as Buerger's disease or simply "generalized arteriosclerosis" is made less often. With acceptance of the feasibility of excisional and replacement therapy, stress has been placed on early treatment of chronic, insidious occlusion of the abdominal aorta before propagation of the thrombotic process occludes the renal or superior mesenteric arteries. Reports of death due to this complication are rare. For this reason the authors report here a fatal case of chronic occlusive disease of the terminal abdominal aorta, which was mistaken for Buerger's disease by others for years. Because corrective therapy was not advised before the terminal episode, the patient died from mesenteric occlusion due to ascending thrombosis of the aorta complicating the disease.

The authors stress the importance of correct, early diagnosis and appropriate treatment in order to avoid serious complications. They advise thorough study of patients with absent femoral pulses and with symptoms of occlusive disease of the abdominal aorta, and re-evaluation of those with a diagnosis of Buerger's disease or "arteriosclerosis" without a localized occlusion. Differentiation from other types of vascular disease should be made and arterial occlusions specifically localized. In addition, they recommend a thorough vascular study for patients presenting persistent symptoms suggesting unexplained urologic, orthopedic, neurologic or general surgical conditions of the abdomen, back or lower extremities.

Medical Management of Perforated Peptic Ulcer. By M. MURRAY SCHECHTER, M.D. J. M. A. Georgia 47:10-12 (Jan.) 1958.

Emphasizing that perforation of a peptic ulcer is a surgical disease and that the chief and most desirable method of therapy is surgical closure of the perforation, this author points out that there are nevertheless numerous instances in which surgery may be contraindicated or refused or in which spontaneous closure is believed already to have occurred. In these instances medical therapy is most applicable. The purpose of this paper is to review the principles, indications, methods and experiences with the medical management of perforated peptic ulcer, since the author regards them as not too well known in this country. He points out that at the present time medical treatment of this complication is to be considered the more radical method of therapy and should be reserved for patients with formes frustes ulcers, perforations less than 12 hours old which show signs of improvement, perforations attended by shock or other poor risk patients, and late perforations which have sealed off and formed abscesses; for those with an equivocal diagnosis; and for those in situations in which surgery is not immediately available, such as aboard ship or in isolated areas. Although this group is small, it is well for the practitioner to be familiar with this alternative method of therapy.

Medical management of perforated peptic ulcer should be used rarely and with extreme caution as suggested by the author.

Fundamental Research on Connective Tissue as it May Apply to the Problems of Aging and Atherosclerosis. By ROBERT J. BOUCEK, M.D. South. M. J. 51:825-826 (July) 1958.

The problems of the aging process and one of the complications of aging, atherosclerosis, occupy a central position in research today. Unquestionably, the author states, this represents the research frontier into which medicine for the next few decades must move, for coronary artery disease, the result of atherosclerosis, is increasing in frequency and apparently occurring in younger and younger males at the most productive period of their lives. It is the purpose of this paper to acquaint the practitioner of medicine with some aspects of research which appear to pertain directly to this problem.

The author recounts interesting studies made over a period of several years on connective tissue obtained by the technic of implanting a relatively inert sponge into the subcutaneous tissues of laboratory animals and human donors. He concludes that the tissue of the blood vessel altered by aging and atherosclerosis is connective tissue and that the suggestive findings presented indicate that a way has been found to isolate connective tissue for a variety of biochemical and physical chemical studies. It is hoped that through such studies, an intelligent approach can be made in the understanding and, perhaps, in the partial regulation of these two most important phases of degenerative diseases.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

A Prayer

"Our Father who art in heaven,"
be his guide,
Watch over him, be ever near his side,
Give him the healing touch, the eyes,
the skill,
To help the cripples and to cure the ill.

Lord, let his voice be low and comforting,
Give him the personality to bring
New hope to those who may despair today,
To drive their anxious hours of night away.

Lord, give him strength to cope,
the rest he needs,
And a joyous heart for his unselfish deeds.
Bless him for all the good that he has done;
Lord, one thing more —
give him some time for fun.

EDITOR'S NOTE: *The Journal is pleased to publish this poem appropriate to the season by Polly McKibben, well known Southern author. The poem, a prayer for the doctor, was sent to the Editor by her husband, Dr. Wm. W. McKibben, of Coral Gables.*

PRESIDENT'S PAGE

Presidents and Secretaries

As we approach the end of an active year, and look forward with anticipation to the commencement of another new one, your Medical Association is readying itself for the initiation of a new project which we hope will be most valuable to the state.

The meeting of the Presidents and Secretaries of the County Societies, on an annual basis, has been inaugurated with the realization of the importance of maintaining adequate communication between the office of the Florida Medical Association, the County Society and its component members.

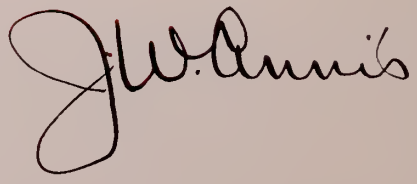
Only insofar as its actions coincide with the desires and opinions of you—the members of the Florida Medical Association—can the Board of Governors feel that it is adequately and conscientiously performing its job.

Since the effectiveness of the programs and the projects of the State Association is directly dependent upon the depth they penetrate into the component County Societies, it was felt that a closer, more frequent and more personal relationship should be established between State and County officers and offices. This meeting has been arranged to implement the free exchange of ideas and information between us. We hope and believe that it will be a successful venture—at least it is a most sincere one.

We welcome you all to Jacksonville, and hope that we will see you here in our new building frequently.

And to each and every one of you—the Doctors of Florida—the officers and the staff of the Florida Medical Association send the Season's Greetings.

Merry Christmas



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The Danger of Agreeing

Frank G. Slaughter, M.D.

A little over nineteen hundred years ago, the Man whose birth the world commemorates at the Christmas season was crucified on a hill outside Jerusalem for being a nonconformist. The great idealistic concepts of Judaism, given by God to Abraham, Isaac, Jacob and Moses, had been largely lost sight of in the ritualism and strict conformity of Pharisaic interpretation. Because Jesus of Nazareth dared to break with this pattern and show man the direct way to God, he lost his life.

We are living today in an age in which the urge toward conformity is already threatening to destroy the freedom of intellectual pursuit without which scientific progress is impossible. Our children have been allowed to neglect mathematics and the sciences, as well as scholastic excellence as an ideal, because they feared the ridicule of their companions. As a result, American science is lagging behind Russian science, a gap which we may never be able to bridge.

In medicine, too, conformity has bred complacency which, tragically, is now taking the lives of infants whose sole crime was that of being born into an age that took the easiest way of the antibiotics and neglected the scrub brush and the soap dish, which men like Semmelweis and Lister proved long ago could protect man from pathogenic bacteria. It is painfully ironic that in an age of medical miracles, the lowliest microbe of them all, the staphylococcus, has become one of man's deadliest enemies.

Medicine is an ever changing science, both in concept and in application. When it ceases to change, it will already be far into a decline. Science has never yet progressed through the blind acceptance of what appears to be established as real truth, and medical science least of all. Behind every major scientific discovery stood a man who refused to be bound by accepted modes of thought—from Marcus Terentius Varro stating the germ theory two hundred years before Christ to Sir Alexander Fleming recognizing one mold in a hundred similarly contaminated Petri dishes as different from all the rest.

Perhaps the most deadly form of conformity, as applied to doctors, is the widespread belief that a man of medicine must be isolated from the affairs of the world. Medicine must always deal not simply with disease but with the whole man in relationship to society, for man cannot long remain healthy in an unhealthy society. The great men of medicine have all been outstanding as intellectuals, as philosophers, or in other ways; one needs only to read the writings of Sir William Osler and Oliver Wendell Holmes to realize this truth once again.

Even Rudolph Virchow, father of cellular pathology, left his microscope long enough to write: "People must feel that they belong together, not on account of a common ancestry, which they perhaps do not have . . . but on account of a spirit in which they live together." What better credo could be laid down in these troubled times when the nations of the world must stand together for peace, or fall separately into oblivion?

The way of the nonconformist is not easy. Men have died in the past because they dared to break with tradition and no doubt will do so again. But only through the example of that cross on the hill of Calvary, which has inspired men through the ages, can they find the way to man's true destination.

Editor's Note: The Journal is honored to have for the sixth consecutive year a guest editorial befitting the Christmas Season from the pen of Dr. Frank G. Slaughter, of Jacksonville, Florida's distinguished physician-author.

Hospital Bed Shortage

Particularly since World War II there has been a constantly increasing demand for hospital beds. It must be recognized that the population has increased, but not in proportion to the hospital bed shortage. This is an attempt to digest and diagnose the reason for this condition. Scientific medicine with many new diagnostic procedures has had a great boom in the past 20 years, resulting in extension of life expectancy and great improvement in the general health of the people of the United States. In Florida the Blue Shield-Blue Cross came into existence in the waning days of World War II. Its birth essentially was a reply to the threat of socialized medicine. As a result of the success of Blue Cross-Blue Shield a tremendous impetus was given to the casualty companies to participate in issuing policies to the scarcely touched health and accident field. Today a majority of the population is provided with some type of insurance protection.

A few insurance companies in the sale of this coverage lead the prospective policyholder to believe that any time he becomes ill or injured he has complete hospital and medical coverage. On such occasions, therefore, the patient usually requests that the doctor hospitalize him in order that he may receive the financial benefits of his policy, which requires hospitalization before claims are paid. As a result, the doctor is often induced to hospitalize a patient who could normally be adequately cared for in the office. There are some doctors who, being exceedingly busy and knowing the patient has insurance, will admit the patient to the the hospital for diagnostic tests, thereby often causing the patient to occupy a much needed bed. The patient will frequently insist that he be permitted to remain in the hospital long after the doctor thinks his condition could well be cared for in the home and, as a result, the doctor feels that he must not be too insistent that the patient leave the hospital.

Recent studies have shown that the hospitalization periods in veteran and other government hospitals are much longer than in civilian hospitals in similar cases. Here the economic factor is of little consequence, and often the patient becomes a "boarder," causing a critical shortage of beds. It should not be forgotten that there are doctors owning and operating small private hospitals. In order to support these hospitals successfully it is necessary to keep the beds fully occupied, a need which, in some cases, influences hospitalization beyond the necessary time.

If physicians could collectively unite and refuse to hospitalize patients for a financial reason only and, if hospitalized, would discharge the patient at the earliest possible moment, then the shortage of beds would be markedly reduced. Furthermore, if Blue Cross-Blue Shield, as well as all the casualty companies, would issue only deductible policies, compelling the patient to pay the first $25 or $50 for hospitalization, a contribution

to the solution of hospital bed shortages would be made and the premium outlay by the patient markedly reduced. The combination of these suggestions certainly would reduce hospital bed shortages by at least 25 per cent.

W. Harold Parham Becomes Association's Executive Director

The Board of Governors of the Florida Medical Association, at its October meeting in Jacksonville, appointed W. Harold Parham to the newly created post of Executive Director, effective Nov. 1, 1958. Joining the staff of the Association in 1949, shortly after graduation from Stetson University, Mr. Parham served first as Supervisor of the Bureau of Public Relations; in April 1954 he became Assistant Managing Director and Supervisor of the Bureau of Public Relations and in April 1958 Associate Managing Director. Last month he assumed the duties of the new executive position which makes him responsible for the management, development, organization, coordination and implementation of the Association's overall program.

The son of Mr. and Mrs. J. R. Parham Sr., the new Executive Director was born in Jacksonville on June 5, 1924. He was graduated from Lee High School in 1943, attended the University of Florida from 1946 to 1948 and received an A. B. degree from Stetson University in 1949.

Prior to entering college, he spent three years in the United States Army during World War II, serving with the 502nd Parachute Infantry, 101st Airborne Division, European Theatre of Operations, and rising to the rank of technical sergeant. After completing his academic education, he joined the Association's staff in October 1949, remaining until he was recalled to active military duty in March 1951. Upon graduation from the Armed Forces Information School, Public Information Course, he served as Medical Historical Editor, Medical Public Information Officer and Administrative Assistant to Surgeon, Headquarters, Eighth Army and United Nations Forces, Korea. Later, as a first lieutenant, he served as Aide-de-Camp to Chief Surgeon, General Headquarters, Far East Command and United Nations Forces, Far East. Upon discharge from military service in October 1952, he returned to his post with the Association.

Mr. Parham is executive secretary of the Florida Medical Foundation, secretary of the Governor's Citizens Medical Committee on Health, and secretary-treasurer of the Committee on Medicine and Hospitals. He holds membership in the Florida Public Relations Association and nationally in the Medical Society Executives Association. Since 1956 he has been a member of the Public Relations Advisory Committee to the American Medical Association.



Mr. Parham

Locally, he is a member of the Meninak Club and the Florida Yacht Club. He is affiliated with the Riverside Park Methodist Church.

December Cover



The Code of Hammurabi

A Babylonian throne room, about 2000 B.C., is the setting for this picture of a physician defending with dignity his professional practices against complaints of a litter-borne, dissatisfied patient who seeks invocation of the drastic penalties of Hammurabi's code. The King, the scribe, court attachés, guards, priests, friends of plaintiff and of defendant, and the usual bystanders, comprise the cast. (Courtesy of Parke, Davis & Company).

In 1950, Mr. Parham and Miss Mary Lucia Copeland of Jacksonville were united in marriage. Mrs. Parham is the daughter of Dr. Silas M. Copeland, a practicing physician in Jacksonville for more than 40 years, and the late Mrs. Copeland, who for many years was active in the Woman's Auxiliary to the Florida Medical Association, serving in various official capacities and as president in 1937. The Parhams have one daughter, Mary Virginia, aged three years.

The Florida Midwinter Seminar Of Ophthalmology and Otolaryngology

Convening for its thirteenth annual session, the Florida Midwinter Seminar of Ophthalmology and Otolaryngology will meet in mid-February this season instead of in January as formerly. As announced in the September Journal, the dates for the 1959 Seminar are February 16 through February 21. The new Americana Hotel in the Bal Harbour section of Miami Beach has been chosen as the meeting place.

The lectures on Otolaryngology come first this year, being scheduled for February 16, 17 and 18. The lecturers are Drs. John J. Conley, of New York; George T. Harrell, of Gainesville; William C. Huffman, of Iowa City; P. E. Ireland, of Toronto, Canada; and Arthur L. Juers, of Louisville.

The lectures on Ophthalmology will follow on February 19, 20 and 21. The lecturers are Drs. Frank D. Carroll, of New York; Paul A. Chandler, of Boston; John W. Henderson, of Ann Arbor; and Harvey E. Thorpe, of Pittsburgh.

The complete program with a schedule of lectures and the titles of all papers will be sent out about December 24. All meetings will be held from 8:30 a. m. to 1:30 p. m., allowing plenty of time for enjoyment of the vacation facilities of Miami Beach.

This Seminar is presented in cooperation with the College of Medicine of the University of Florida and the University of Miami School of Medicine. Sponsoring this unusually popular winter graduate course are in the Division of Ophthalmology, Drs. Shaler Richardson and Charles W. Boyd, of Jacksonville; Joseph W. Taylor Jr., of Tampa; and Kenneth S. Whitmer and Edward Norton, of Miami; and in the Division of Otolaryngology, Drs. Walter T. Hotchkiss, of Miami Beach; G. Dekle Taylor, of Jacksonville; Carl S. McLemore, of Orlando; and James R. Chandler Jr., of Miami.

Florida Physicians Participating In Southern Medical Association Program

Floridians contributed their share to the excellent scientific program presented at the Fifty-Second Annual Meeting of the Southern Medical Association, which was held in New Orleans early last month. Some 300 papers were presented in the 20 sections representing the major medical and surgical specialties. Among the participants were 22 physicians from various sections of the state: Drs. Harriet E. Gillette, of Gainesville; James J. Conners, and Clarence M. Sharp, of Jacksonville; Woods A. Howard, of Lakeland; George H. Hames, of Lantana; W. A. D. Anderson, J. Gerard Converse, Harry E. Danielson Jr., Norman M. Kenyon, Donald F. Marion, William H. Meyer, Howard A. Novell, Raymond E. Parks, George R. Prout Jr., John M. Rumball, Wiley M. Sams and William K. Shorey, of Miami; Courtlandt D. Berry, Louise P. Brady and Bright McConnell Jr., of Orlando; Stephen P. Gyland Sr., of Tampa; and Theodore Norley, of West Palm Beach.

Discussing papers were: Drs. James G. Lyerly Sr. and John T. Stage, Jacksonville; Harvey Blank and J. Gerard Converse, Miami; Peter B. Wright, Orlando; and Richard T. Farrior, Tampa.

County Medical Society Presidents and Secretaries First Annual Conference Jacksonville, December 14, 1958

The 1959 incoming presidents and secretaries of all component county medical societies will gather in Jacksonville on December 14 for a meeting sponsored by the Florida Medical Association. As announced in the November Journal, the meeting will take place in the Duval County Medical Society Building (Sellers Auditorium) at the foot of Lomax Street, convening at 9 a.m. and adjourning about 4 p.m. This initial conference is expected to be continued on an annual basis and should prove mutually beneficial to the county societies and to the Association.

The comprehensive program for the occasion covers the current medical problems, plans and programs at the county, state and national levels. Its scope emphasizes its value to the presidents and secretaries of the county societies who will take office in 1959. Every county society will undoubtedly wish to be represented by these incoming officers, and a large attendance is anticipated. The program follows:

PROGRAM FOR CONFERENCE

1959 COUNTY MEDICAL SOCIETY PRESIDENTS AND SECRETARIES

Sponsored by the Florida Medical Association

SUNDAY, DECEMBER 14, 1958

DUVAL COUNTY MEDICAL SOCIETY BUILDING
JACKSONVILLE

MORNING SESSION

Jere W. Annis, M.D., President, Florida Medical Association, presiding

9:00 a.m.—Registration	
9:15 a.m.—Welcome to Assembly (Purpose of Meeting)	Jere W. Annis, M.D.
9:30 a.m.—Current Problems and Programs of the AMA	Ernest B. Howard, M.D.
9:55 a.m.—Responsibilities of the County Medical Society President	William C. Roberts, M.D.
10:20 a.m.—Duties of the County Medical Society Secretary	Samuel M. Day, M.D.
10:45 a.m.—Legislation—Past and Future (State and National)	H. Phillip Hampton, M.D.
11:10 a.m.—Medicare	Burns A. Dobbins Jr., M.D.
11:35 a.m.—Our Positive Public Relations Program	Edward Jelks, M.D.
11:55 a.m.—Role of the Woman's Auxiliary	Mrs. Lee Rogers
12:00 —I've Got a Question	

12:30 p.m.—Complimentary Luncheon and Tour of Florida Medical Association Building.

AFTERNOON SESSION

Samuel M. Day, M.D., Secretary-Treasurer, Florida Medical Association, presiding

2:00 p.m.—Panel on Medical Economics and Insurance	S. Carnes Harvard, M.D. Robert E. Zellner, M.D.
2:25 p.m.—Governor's Citizens Medical Committee on Health	Edward R. Annis, M.D.
2:50 p.m.—Our Blue Shield	Russell B. Carson, M.D.
3:15 p.m.—Things to Watch For	Jere W. Annis, M.D.
3:40 p.m.—I've Got a Question	
4:00 p.m.—Adjournment	

Scientific Work Committee Plans for 1959 Meeting

The Committee on Scientific Work wishes to express its appreciation of the many and varied responses to its request for scientific papers for the Association's 1959 annual meeting. The suggestions submitted vary all the way from psychology to urologic surgery, from the history of medicine to steroid chemistry; so the task of the Committee will not be hampered by lack of diversified material. It is the intention, if possible, to have a symposium or panel so as to group several papers together.

As the December Journal goes to press, the Committee chairman, Dr. Lawrence E. Geeslin, wishes to emphasize that there is plenty of space available for scientific exhibits. Because these exhibits take time and are troublesome to prepare, too few are presented at the annual meetings. It is well to recall the Chinese saying that a picture is worth a thousand words. If members of the Association have information on any particular subject that they think should be imparted to the profession, they should consider the exhibit as probably the clearest way of getting this information across in outline form.

Important to note at this time is the decision to omit the annual banquet at the 1959 meeting. This omission will allow Tuesday evening for additional meetings or for transfer of regular meetings of specialty societies and other groups, some of which may wish to schedule a small dinner. It is hoped this arrangement will prevent some of the conflict that occurred previously on Saturday and Sunday when all of the specialty society groups were trying to have their meetings concur-

rently. Many of the Association members wished to hear some of the speakers in two or three meetings which were held at the same time. This change, therefore, will allow a spreading out of the specialty group meetings.

Dr. Geeslin urges the members to pass the word along that exhibit space is available, but for programing reasons the Committee must know as soon as possible who wishes to submit an exhibit. Publication has to be decided upon in January when the full Committee meets to complete the program.

Drs. Creekmore and Harvard Honored Dr. Annis Guest Speaker

In recognition of their many years of faithful and untiring service to the people of Brooksville and Hernando County, Dr. George R. Creekmore and Dr. S. Carnes Harvard, prominent local physicians, were signally honored by the Kiwanis Club of that city at a special banquet in the Veterans Building on October 23. The occasion, which came as a complete surprise to both doctors, was highlighted by the presentation of a beautifully engraved plaque to each of them as a remembrance of the event and by a standing ovation from the more than 200 men and women of the community and county who were in attendance. Dr. Creekmore has practiced medicine in Brooksville for more than four decades, and Dr. Harvard for a quarter of a century. Serving as master of ceremonies was Alfred A. McKethan, local banker, and Dr. Chan Springstead, local dentist and president of the Kiwanis Club, presented the plaques.

Special guest and speaker for the occasion was Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, of which Dr. Harvard is now serving as Vice President. After expressing his personal pleasure at having the honor of participating in the program and also expressing the pride of the Florida Medical Association in this lay tribute to two of its members, Dr. Annis declared, "Here are two great men of Medicine—great by the true measures of stature by which we measure the dignity of man—great because they have dedicated their entire lives to a calling which is virtually a faith and a religion to them." Briefly he then traced the history of Medicine, the oldest professional class in the evolution of society, from the darkest recesses of antiquity across the centuries to Imhotep, Aesculapius, Hippocrates, Huang Ti and on to modern times.

"And so on down through the ages," he continued, "—the great men of Medicine: the Galens, the Parés, the Listers, the Hunters, the Oslers, and the Mayos—strong, outstanding figures that have done so much for mankind. But marching along with them, and of equal importance to the human race—and of far greater importance to you and me as individual patients suffering with some illness or disease—have been the hosts of quiet, devoted, self-sacrificing practitioners of this great profession— the little men, if you will, who are indeed little giants—the men who, within the memory of many of those here, traveled the country roads in a horse and buggy—bundled up against the elements, and quietly and undramatically plodded along through the night to the bedside of some sick human brother. These men have served a faith—a religion of their own—with little thought of recompense; with no thought of glory or gain except for the tremendous heart-warming satisfaction which comes from the accomplishment of their mission in life. These are the men who have slaved for the accomplishment of ideals and principles—who have, in the eyes of the laity, worked long and hard and without reward. But this is not so, and I am sure that these two gentlemen here with you tonight will be first to corroborate my statement in this regard. These men have found a joy—a satisfaction—a rich reward greater than any that it is within the power of man to bestow upon them. They have achieved within themselves a peace and satisfaction which has more than compensated them for the hardships and the struggles which they have endured. Truly they are well paid.

"You have with you tonight — as you know — one physician who has traveled these very country roads about which I have spoken, in a horse and buggy—who has practiced Medicine without any of the refinements and the advantages which we come to expect and demand today —who has had to rely upon his ingenuity, experience and quick wit to provide himself with the best possible answers to difficult problems.

"Dr. Creekmore began his practice in Medicine during the days of the horse and the buggy, during the days of bad roads and few conveniences — began this practice even before he came to Brooksville some 41 years ago — and long before he bought his first automobile in 1911 . . . .



Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, (second from left) stands with Dr. George R. Creekmore and Dr. S. Carnes Harvard following presentation of plaques. Mr. Alfred A. McKethan, president of the Hernando State Bank of Brooksville (extreme left) was in charge of the program. Dr. Chan W. Springstead (extreme right) is president of the Brooksville Kiwanis Club.

It is men such as Dr. Creekmore who have supplied the firm foundation on which modern Medicine stands. It is to these men that we, the doctors of the State of Florida — the doctors of the Florida Medical Association — owe so much in gratitude and appreciation. And it is with the utmost appreciation that we acknowledge your realization as a community of your indebtedness to a member of our profession who, throughout the years, has served you so faithfully and so well — and who, I am sure, must be classed as the Senior Citizen of Brooksville . . . .

"And now, Dr. Harvard — the things I have said about Dr. Creekmore certainly apply to him, too — except the year he graduated from Medical School. Dr. Harvard graduated from Emory in 1930 and came here in 1932. Since then he has provided this community with the finest type of medical care available anywhere — has brought all the advantages of modern medical achievement here to your doorstep. Long respected and admired in the Florida Medical Association, he has been the close friend upon whom we have often relied to accomplish the difficult jobs. We love him—respect him—and depend on him just as this community has done for the past 25 years . . . . It is a real pleasure to be here and have a part in this ceremony honoring an old friend."

Mr. McKethan then expressed appreciation of the faithful service to the community always willingly rendered through the years by the two physicians, and of their role as Kiwanians and as citizens. He paid special tribute to the part they have played in the progress of the community and also in the great work they have done in the children's programs sponsored by the organization. Both speakers mentioned the background and reviewed the accomplishments of the doctors through the years. Dr. Creekmore was licensed to practice medicine in Florida in 1906, the same year he was graduated from the University of Georgia Medical Department, now the Medical College of Georgia. He located in Brooksville in 1917 and has remained in active practice there since that time. It was through the efforts of Dr. Creekmore, assisted by the late Dr. W. S. Hancock Jr., and Dr. A. C. Coogler, that the Hernando General Hospital, the forerunner of the present Hernando County Hospital, was organized. He served for many years as County Physician, as a member of the staff of both local hospi-

tals, as Seaboard Air Line Railroad physician and as County Commissioner. He is a past president of the Tri-County Medical Society and of the Kiwanis Club and is active in the First Baptist Church.

Dr. Harvard received his medical degree from Emory University School of Medicine in 1930 and entered the practice of medicine in Brooksvillle in January 1933. He took a leading part in the building of the present modern Hernando County Hospital and has served for years as a member of of its staff and as resident surgeon. He has also served as County Physician and is the Atlantic Coast Line Railroad physician. He is a past president of the Tri-County Medical Society, and in addition to his present post of Vice President, he is chairman of the Committee on Medical Economics of the Florida Medical Association. Recently, he was appointed by Governor Collins as a member of the State Board of Medical Examiners of Florida.

The program on this happy occasion reached an enjoyable climax when Mr. McKethan declared that the local doctors had truly left their footprints on the sands of time, Dr. Creekmore having delivered several thousand babies in his 41 years of practice in Brooksville, and Dr. Harvard having delivered 3,285 at last count. This program of recognition affords a gratifying example of excellent public relations between the laity and the medical profession in a progressive and appreciative community.

Florida Diabetes Association Annual Meeting Held

Dr. Joseph J. Lowenthal, of Jacksonville, acceded to the presidency of the Florida Diabetes Association at the closing session of its sixth annual meeting, held in Miami Beach on October 30 and 31. Other officers elected were Dr. Grover C. Collins, of Palatka, president-elect for 1960, and Dr. Morris B. Seltzer, of Daytona Beach, secretary-treasurer. Named to the board of directors were Dr. T. Z. Cason and Dr. L. L. Parks, of Jacksonville, Dr. Richard Sinden, of St. Petersburg, and Dr. A. Gorman Hills, of Miami.

Presiding over the meeting was Dr. George H. Garmany, of Tallahassee, 1958 president of the group. Some 75 physicians were in attendance, the largest number yet recorded. This record attendance, the excellent scientific program and the interest manifested by the laity made this one of the most successful meetings this organization had ever held. Over 100 attended the session for the lay public on Thursday night in the pleasant surroundings of the Bal Moral Hotel in Bal Harbour, where the meeting was held.

Guest speakers at the scientific session and at the meeting for the laity were Dr. James B. Field, Bethesda, Md., Dr. Thomas F. Frawley, Albany, N. Y., and Dr. Howard F. Root, Boston. Member speakers were Dr. Lowenthal, Dr. Hills, and Dr. William C. Thomas Jr., of Gainesville.

Cooperating with the Florida Diabetes Association in this meeting were the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association.

Southeastern Regional Convocation United States Section International College of Surgeons Miami Beach, January 4-7, 1959

A cordial invitation is extended to members of the surgical and allied professions and their families to attend the Southeastern Regional Convocation of the United States Section of the International College of Surgeons early next month at the Americana Hotel, Bal Harbour, Miami Beach. The meeting will open at noon on Sunday, January 4, and continue through Wednesday noon, January 7. For the registration fee of $10, both members of the College and nonmember surgeons may attend all scientific sessions, and there is no charge for residents, interns and medical students. The program is approved for 10 hours of credit in Category I for members of the American Academy of General Practice.

Opening the Convocation on Sunday at 2:30 p.m. will be Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine. Dr. Frank L. Meleney will serve as honorary chairman and Dr. Harold O. Halstrand as general chairman; both are members of the faculty of the local medical school. Dr. Don C. Robertson, of Orlando, Regent of the College for the State of Florida, will serve as secretary of the General Assembly.

The program contains a roster of distinguished names in medicine. There will be more than 90 speakers from the United States, Canada, Belgium, Cuba and South America, most of whom

are internationally known in their fields. Scheduled for active participation in the program are faculty members from the University of Miami School of Medicine and the College of Medicine of the University of Florida and eminent authorities in their particular subjects from the Mayo Clinic, Memorial Center for Cancer and Allied Diseases, Northwestern University Medical School, University of Illinois College of Medicine, Ohio State University College of Medicine, University of Texas Southwestern Medical School, Temple University School of Medicine, Hahnemann Medical College and Hospital of Philadelphia, Cornell University Medical College, University of Virginia School of Medicine, Medical College of Georgia, Emory University School of Medicine, University of Tennessee College of Medicine, Tulane University School of Medicine, Western Reserve University School of Medicine, University of Minnesota Medical School, Cook County Graduate School and Hospital, Children's Hospital of Philadelphia, George Washington University School of Medicine, University of Pennsylvania School of Medicine, State University of New York College of Medicine, Wayne State University College of Medicine, University of Pittsburgh School of Medicine and University of Havana Medical School.

Closed circuit color television from the St. Francis Hospital to the Americana Hotel will be presented in the Medallion Room on Monday, Tuesday and Wednesday from 9 a.m. to 1 p.m. The daily cinema program features excellent new surgical motion pictures.

Highlighting the meeting will be the dinner-dance banquet on Tuesday night, January 6, at the Americana. Dr. Louis M. Orr, of Orlando, President-Elect of the American Medical Association, will be the principal speaker.

A full program of activities for the ladies has been scheduled. Mrs. Manuel Schofman is the local chairman for the International College of Surgeons Woman's Auxiliary.

Since the meeting occurs immediately after the holidays and the Orange Bowl festivities and at the beginning of the Miami winter season, rooms will be in great demand. Reservations should be made at once directly with the Americana Hotel, Bal Harbour, Miami Beach. Advance registrants for the Convocation may apply for the limited number of box seats available for the King Orange parade and the Twenty-Fifth Annual Anniversary Orange Bowl football game. The applications will be processed in the order received until the ticket supply is exhausted. For advance registration contact Harold O. Hallstrand, M.D., General Chairman, International College of Surgeons, 7210 Red Road, South Miami.

College of Medicine and University Hospital Postgraduate Surgical Seminar Gainesville, January 15-17, 1959

A seminar designed for practicing surgeons interested in maintaining knowledge of recent developments in thoracic and gastrointestinal surgery will be held at the College of Medicine of the University of Florida in Gainesville on January 15, 16 and 17, 1959. On the day devoted to problems encountered in surgery of the alimentary tract, material to be presented will embrace recent advances in the physiology of the esophagus and the application to esophageal surgery, newer technics in the management of massive gastrointestinal hemorrhage, and surgery for ulcerative colitis and diverticulitis.

The program on the second day will be limited to consideration of problems in thoracic surgery. Topics to be discussed include management of acute trauma to the chest, the use and care of tracheotomies, the pathogenesis and changing concepts in management of chronic pulmonary infections, and surgery for pulmonary carcinoma. In addition, there will be a conference on the use and abuse of muscle relaxants. On the final half day there will be participation with members of the surgical department in a surgical-pathologic conference and in surgical rounds.

The registration fee for this seminar will be $25. There will be no charge for hospital interns and residents who wish to attend.

Speakers at this seminar will be Dr. J. Garrott Allen, Professor of Surgery, University of Chicago, the School of Medicine, Dr. Thomas H. Burford, Professor of Surgery and Chief of Thoracic Surgery, Washington University School of Medicine; and the following members of the faculty of the College of Medicine of the University of Florida: Dr. Edward R. Woodward, Professor and Head, Department of Surgery; Dr. Thorkild Andersen, Assistant Professor of Surgery; Dr. Joachim S. Gravenstein, Assistant Professor of Surgery and Chief of Anesthesia; Dr. John Reeves, Professor and Head, Department of Radiology; Dr. William W. Stead, Associate Professor of Medicine; and

Dr. Myron W. Wheat, Assistant Professor of Surgery, Chief of Thoracic Surgery.

For information write to Dr. William C. Thomas Jr., Director, Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

OTHERS ARE SAYING

Personal Responsibility

Some years ago the late Dr. Hamilton Holt, for many years president of Rollins College, in discussing the influence of a profession on a man's life said, "For a number of years I have had the opportunity of observing many young people mature. I think that my own profession, journalism, is the most broadening; the practice of law, the most intellectual; the ministry, the most uplifting; but the practice of medicine is the most ennobling. Most medical students are a rather rowdy lot; but by the time they have practiced medicine for forty years they are usually pretty fine people."

Maybe it's because I have had to put on bifocals recently, or possibly it's because as a member of the Committee of 17 and of the County Medicare Committee I have been brought face to face with some of medicine's serious problems —whatever it is, I have been aware of an ever-increasing sense of responsibility and feeling of obligation to my profession. One of the things which impressed me most when I first started to practice was the frequency with which people old enough to be my grandparents would come to me with personal problems much beyond the realm of my experience and be perfectly willing to take my advice, not because of what I knew, but simply because I was a doctor.

I know of no other profession or field of endeavor in which a young man begins his work so heavily endowed. He is learned; he is honorable; he is ethical; he is decent—until he proves otherwise, which fortunately, only a small minority ever does. Having inherited such a reputation, each of us has the obligation; first, to earn it by the way we practice and by the way we live; and, second, to pass it on to our successors in a condition as bright and clean as it was when we received it.

PR may mean Puerto Rico to some, Public Relations to others; but to us it should mean

atlanta graduate medical assembly

Mark It On Your Calendar NOW

February 16, 17, 18, 1959 Atlanta Biltmore Hotel ATLANTA, GA.

More "Afternoon Roundtables"
More "Luncheon Conferences"
"Meet Your Friends and Colleagues at the AGMA"

Speaking Faculty
February 16-18, 1959

Stewart Wolf, M.D. .....*Oklahoma City, Okla.*
Ethan Allan Brown, M.D. .....*Boston, Mass.*
Edward H. Rynearson, M.D. . *Rochester, Minn.*
William G. Sauer, M.D. .....*Rochester, Minn.*
William Dameshek, M. D. .....*Boston, Mass.*
B. Marden Black, M.D. .....*Rochester, Minn.*
Warren H. Cole, M.D. .....*Chicago, Ill.*
Denton A. Cooley, M.D. .....*Houston, Texas*
Averill A. Liebow, M.D. ...*New Haven, Conn.*
Vincent J. Collins, M.D. .....*New York, N. Y.*
Charles M. Nice, Jr., M.D. ..*New Orleans, La.*
Curtis J. Lund, M.D. ....*Rochester, New York*
A. Ashley Weech, M.D. .....*Cincinnati, Ohio*
Lee E. Farr, M.D. ...*Upton, Long Island, N. Y.*

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IN DEBILITATING DISEASE



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Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

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The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg. and ampuls of 25 mg. (1 cc.).

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SEARLE

PERSONAL RESPONSIBILITY—responsibility to the community, to those who look to us for advice and care, to the profession which provides us not only with a livelihood but with a way of life, and to each other. When asked, "Am I my brother's keeper?", the answer is "Yes." Anything shady or dishonorable which any one of us does reflects to the discredit of the entire profession. None of us is a free agent and there is no room for the rugged individualist in medicine if his individualism means a disregard for his obligation and responsibility to his profession and to his fellow physician.

The ever-increasing complexity of the practice of medicine, which includes social, economic, and the political problems as well as the purely professional, makes it imperative that every physician keep himself informed and that he take the long view of every situation with due regard for his obligation to his fellow physician, to his profession, and to the community. If he does, possibly he will become forty years later one of those doctors of whom Dr. Holt was speaking.

Robert E. Zellner, M.D., President
Orange County Medical Society
Quarterly Bulletin
April, May, June, 1958

STATE NEWS ITEMS

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, by invitation joined 60 other leaders from various professions, the fields of business, labor, news media and education at Miami Beach October 30-November 2 for a Florida Assembly, the theme of which was "Atoms for Power." The Assembly was sponsored by the University of Florida in cooperation with the American Assembly of Columbia University.

Dr. Joseph L. Rubel of Pensacola has been installed as president of the Escambia Pediatric Society following his election at the Society's annual meeting held the last of September. Dr. Egbert V. Anderson was elected vice president and Dr. John H. Whitcomb, secretary-treasurer. They are also from Pensacola.

A training program for general practitioners who desire to receive postgraduate training in psychiatry or who may desire to undertake residency training in order to become psychiatrists has been announced by the National Institute of

Announcing The Twenty-Second Annual Meeting
of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters — Roosevelt Hotel
March 2, 3, 4, 5, 1959

GUEST SPEAKERS

Paul R. Dumke, M.D., Detroit, Mich. Anesthesiology
Otto H. Janton, M.D., Philadelphia, Penna. Cardiology
Carl T. Nelson, M.D., New York, N. Y. Dermatology
Clifford J. Barborka, M.D., Chicago, Ill. Gastroenterology
Malcom E. Phelps, M.D., El Reno, Okla. General Practice
Keith P. Russell, M.D., Los Angeles, Calif. Gynecology
William Dameshek, M.D., Boston, Mass. Internal Medicine
Howard P. Rome, M.D., Rochester, Minn. Neuropsychiatry
R. Gordon Douglas, M.D., New York, N. Y. Obstetrics
Maynard C. Wheeler, M.D., New York, N. Y. Ophthalmology
Lenox D. Baker, M.D., Durham, N. C. Orthopedic Surgery
Ben H. Senturia, M.D., St. Louis, Mo. Otolaryngology
Francis Bayless, M.D., Cleveland, Ohio Pathology
Lee F. Hill, M.D., Des Moines, Iowa Pediatrics
Roy R. Greening, M.D., Philadelphia, Penna. Radiology
John M. Dorsey, M.D., Evanston, Ill. Surgery
F. Henry Ellis, M.D., Rochester, Minn. Surgery
Fred K. Garvey, M.D., Winston-Salem, N. C. Urology

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures and technical exhibits.
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Mental Health of the Department of Health, Education and Welfare. Inquiries about the program should be sent to Dr. Seymour D. Vestermark, Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Md.

Dr. J. K. David Jr. of Jacksonville was one of the principal speakers at the State Conference of Negro Principals and Supervisors held the last of October at Bethune-Cookman College at Daytona Beach. The title of Dr. David's address was "The Physician's Role in School Health." He represented the Florida Medical Association as a member of the School Health Medical Advisory Committee to the State Department of Education and the Florida State Board of Health.

Six new grants for phases of medical research have recently been awarded to the University of Miami School of Medicine, according to a report by Dr. Homer F. Marsh, Dean. With these grants, the School of Medicine has 102 projects in research under way with a total of more than $1,300,000 in funds allocated for their support.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, attended a dinner meeting of The Ridge Chapter, Florida Engineering Society, November 13 held in Lakeland and participated in a symposium on "Professionalism."

Drs. Roberts Davies of Tallahassee, Benjamin L. Brock of Orlando and M. Eugene Flipse of Miami participated in the program of the fourth annual case conference on tuberculosis held the latter part of October at Ponte Vedra Beach. It was attended by physicians from Florida, Georgia and South Carolina. Principal speakers were Dr. Carroll E. Palmer, U. S. Public Health Service, Washington, D. C., and Dr. Ejvind Fenger, assistant medical director of Glen Lake Sanatorium, Oak Terrace, Minn.

Dr. Ashbel C. Williams of Jacksonville has been elected a director of the American Cancer Society for Region III embracing the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia.

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Dr. Simon D. Doff of Jacksonville, president of the Florida Heart Association, participated in the program of the 34th Annual Meeting of the American Heart Association held the last of October in San Francisco.

Mr. Michael J. Pickering of Starke was recently presented the Dr. Stewart Thompson award in ceremonies at the University of Florida College of Medicine. The Award is made annually to the outstanding student of the first year class in the College of Medicine as selected by a faculty committee. It is presented by the Marion County Medical Society through Dr. Richard C. Cumming of Ocala.

Drs. Elwyn Evans of Orlando and Victor H. Kugel of Miami Beach were principal speakers on the program of the Institute on Cardiovascular Rehabilitation held the first of October at the J. Hillis Miller Health Center, Gainesville.

A cancer seminar is being sponsored by the Alabama Division of the American Cancer Society on January 28-29 at the Dinkler-Tutwiler Hotel in Birmingham in cooperation with the Medical Association of Alabama, the Jefferson County Medical Society and the Academy of General Practice.

Dr. John T. Benbow, clinical director of the Florida State Hospital at Chattahoochee, has been appointed superintendent of the new Northeast Florida Mental Hospital at Macclenny.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was one of the principal speakers at the recent Festival of Faith held at Tyronza, Ark. Approximately 2,000 persons outstanding in their respective fields of medicine, religion, business, education and politics attended the unique gathering.

Dr. George T. Harrell Jr., Dean of the College of Medicine, University of Florida, delivered the dinner address at the 9th annual Winston-Salem Heart Symposium held at Winston-Salem, N. C.,

(Continued on page 696)



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you were to examine these patients



could you detect the uveitis patient on Medrol*?

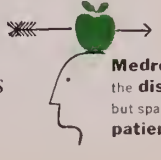
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol hits the **disease,** but spares the **patient**

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(Continued from page 692)

early in October. The title of Dr. Harrell's address was "Fats in your Future."

Drs. Lorenzo L. Parks, Albert V. Hardy, Simon D. Doff and Wilson T. Sowder of Jacksonville represented Duval County at the first Florida Governor's Conference on Aging held at Tallahassee the middle of October.

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Dr. Hyman Sporn of Hollywood has returned after spending the summer in Vienna where he did postgraduate work at the University of Vienna.

A sectional meeting of the American College of Surgeons has been scheduled for January 19-21 at the Francis Marion Hotel, Charleston, S. C. A program covering many topics of current concern, including trauma, cancer, arterial occlusive disease, management of gastrointestinal tract hemorrhage and abdominal emergencies is being planned by Dr. Kenneth M. Lynch Jr. of Charleston and his committee of local surgeons.

The annual session of the American Society of Anesthesiologists was held November 17-21 in the Palmer House, Chicago, following postponement of the meeting originally scheduled for Pittsburgh. Dr. Ralph S. Sappenfield of Miami served as president during the year 1958.

Dr. Coy L. Lay of Lakeland has been installed as medical vice president of the Lakeland Cancer Committee.

Dr. S. Charles Werblow of Miami Beach has been honored with a testimonial dinner sponsored by the Doctors Committee of the Mt. Sinai Hospital Development Fund. Dr. Werblow has served as chairman of the Doctors Division for the Combined Jewish Appeal and as co-chairman of the Doctors Division of the United Fund.

Dr. Robert G. Cushman of Jacksonville was principal speaker at a recent meeting of the



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you were to examine these patients



could you detect the asthmatic on Medrol*?

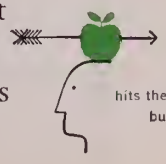
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?

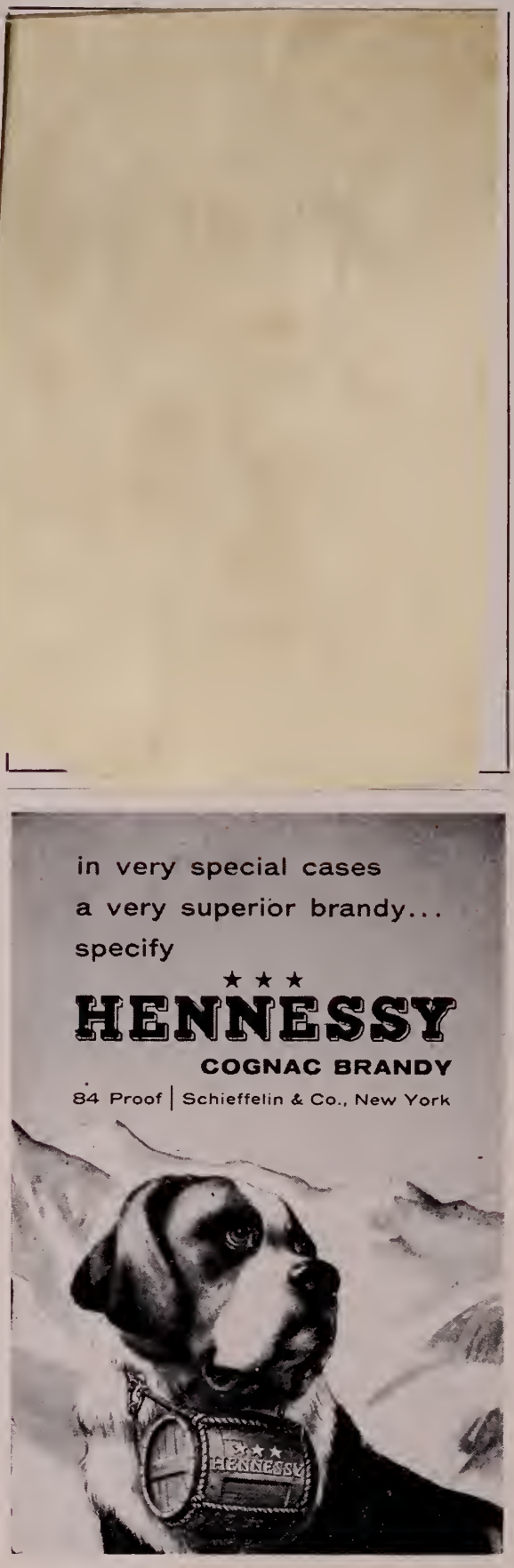


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Duval Chapter, Florida Society of Medical Technologists, held at Jacksonville.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, represented the Association at the Ninth Annual Fire Conference held in Miami, October 29-30, the Ninth Annual Scientific Assembly of the Florida Academy of General Practice held at West Palm Beach October 30 - November 1, and at the meeting of the Florida Division of the American Cancer Society held at West Palm Beach, November 15-16.

Dr. Thomas S. Edwards of Jacksonville was one of the principal speakers on the program for the meeting of The Association for Research in Ophthalmology held November 3 conjointly with the Southern Medical Association meeting in New Orleans. The title of Dr. Edwards' address was "Changes in Bacterial Drug Sensitivities."

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. J. Champneys Taylor of Jacksonville announce the birth of a daughter, Louise Little, on August 11, 1958.

Dr. and Mrs. Sanford A. Mullen of Jacksonville announce the birth of a son, Michael Hill, on August 30, 1958.

Dr. and Mrs. Apostolos Kartsonis of Jacksonville announce the birth of a son, John Paul, on August 8, 1958.

Dr. and Mrs. Virgilio B. De Padua of Jacksonville announce the birth of a daughter, Patricia Garcia, on October 17, 1958.

Dr. and Mrs. John B. McCall Jr. of Jacksonville announce the birth of a son, Moody Clarkson, on October 18, 1958.

Marriages

Dr. John A. Broward of Coral Gables and Miss Marcia Kay Chandler also of Coral Gables were married there on October 4, 1958.

Dr. Henry C. White Jr. of Fort Walton Beach and Mrs. Mary Brooks Moreman also of Fort Walton Beach were married in Pensacola September 3, 1958.

Deaths — Members

Council, Melton D., Vero Beach ..... October 5, 1958
Field, Thomas S., Jacksonville..... October 12, 1958

Deaths — Other Doctors

Cannaday, John E., Charleston, W. Va..... June 29, 1958
Cook, Elbert Clancy, Bradenton..... June 5, 1958
Hilliard, Charles Wesley,
Winter Haven ..... September 23, 1958
Killoran, Vincent A., Fort Lauderdale..... July 26, 1958
Prescott, Blake Daniels,
Springfield, Mass ..... February 21, 1957
Schaff, Burnett, Coral Gables..... June 16, 1958
Scott, Edwin Laurence, Ocala ..... October 10, 1958
Wallace, Henry, New York, N. Y..... April 24, 1958

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Capsules / Oral Suspension

designed for effective control of common gram-positive infections

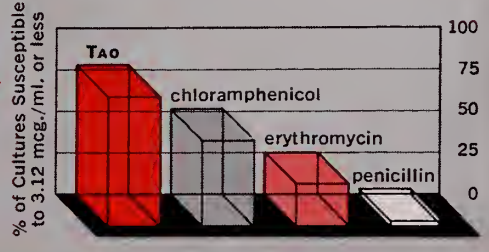
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

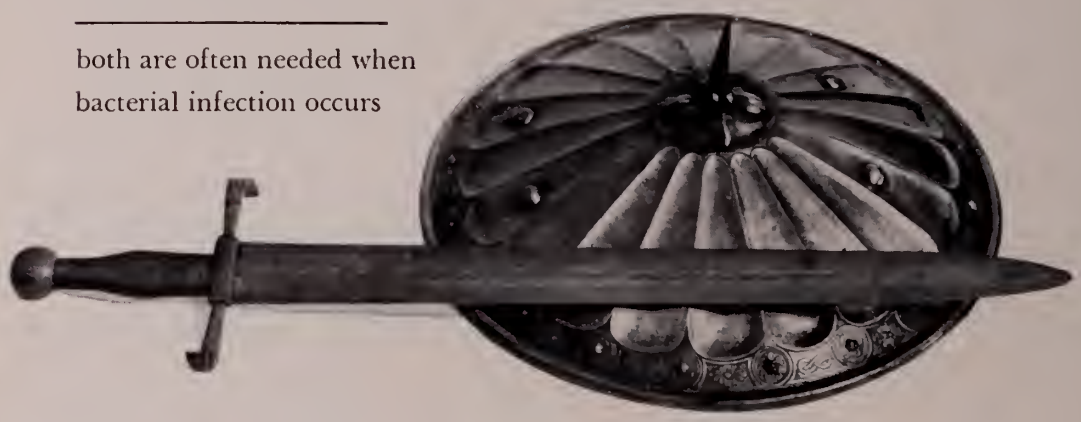
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both are often needed when
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Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications

Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

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They are physiologically standardized,
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Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
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Average Dose:

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a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
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Decadron*

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

a new order of magnitude

In Anti-Inflammatory Potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

In Dosage Reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

In Elimination and Reduction of Side Effects

Virtual absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions has been noted with DECADRON.[1,2,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and digestive complaints were rare. Nor have there been any new or "peculiar" side effects, such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia or erythema. Thus DECADRON introduces a new order of magnitude in safety, unprecedented in corticosteroid therapy.

In Therapeutic Effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency.[4] Clinically, this was manifested by a higher degree of improvement in many patients, previously treated with prednisteroids,[3] and by achievement of satisfactory control in an impressive number of recalcitrant cases.[3,4]

In Therapeutic Range

More patients can be treated more effectively with DECADRON. Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nearly all patients on DECADRON, assures greater patient cooperation.

References:

1. Boland, E.W.: California Med. *88*:417 (June) 1958.
2. Bunim, J.J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958.
3. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.
4. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

DOSAGE AND ADMINISTRATION

With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

One 0.75 mg. tablet of DECADRON (dexamethasone) replaces:

↓ One 4 mg.	↓ One 5 mg.	↓ One 20 mg.	↓ One 25 mg.
tablet of methylprednisolone or triamcinolone	tablet of prednisolone or prednisone	tablet of hydrocortisone	tablet of cortisone

SUPPLIED:

As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets to provide maximal individualized flexibility of dosage adjustment.

Detailed literature is available to physicians on request.

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Decadron*

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The great corticosteroid era
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Today, MERCK SHARP & DOHME proudly
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achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy



Decadron

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society has paid 100 per cent of its state dues for 1958.

Brevard

Dr. Gerard E. Christie, of Titusville, described the manner in which funds were raised for constructing and equipping the North Brevard Hospital at Titusville at the September meeting of the Brevard County Medical Society held at the Whispering Hills Country Club, Titusville. Presiding at the meeting was Dr. Jack T. Bechtel, of Eau Gallie, president of the Society.

DeSoto-Hardee-Highlands-Glades

Dr. James N. Patterson, of Tampa, was principal speaker for the October meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society held in Wauchula. The title of Dr. Patterson's address was "Recent Advances in Laboratory Methods."

Duval

"Civil Defense" was the principal topic discussed at the November meeting of the Duval County Medical Society. Dr. Gary E. Turner, of Jacksonville, chairman of the Society's Civil Defense and Disaster Committee, was in charge of the program.

Lake

Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, and Dr. Don C. Robertson, of Orlando, Councilor for the Association's Fourth Medical District, were principal speakers at the October meeting of the Lake County Medical Society held at the Fountain Inn Hotel in Eustis. Following the general program a business meeting was held at which indigent care within the county was discussed.

Manatee

Dr. Lowrie W. Blake, of Bradenton, was honored by the Manatee County Medical Society at a meeting held early in October at the Bradenton Country Club. During the evening, members of the Society presented Dr. Blake a scroll in recognition of his service to the community and medical profession. Making the presentation was Dr. Eugene E. Biel, of Bradenton, president of the Society.

(Continued on page 710)

HYPERTENSION?



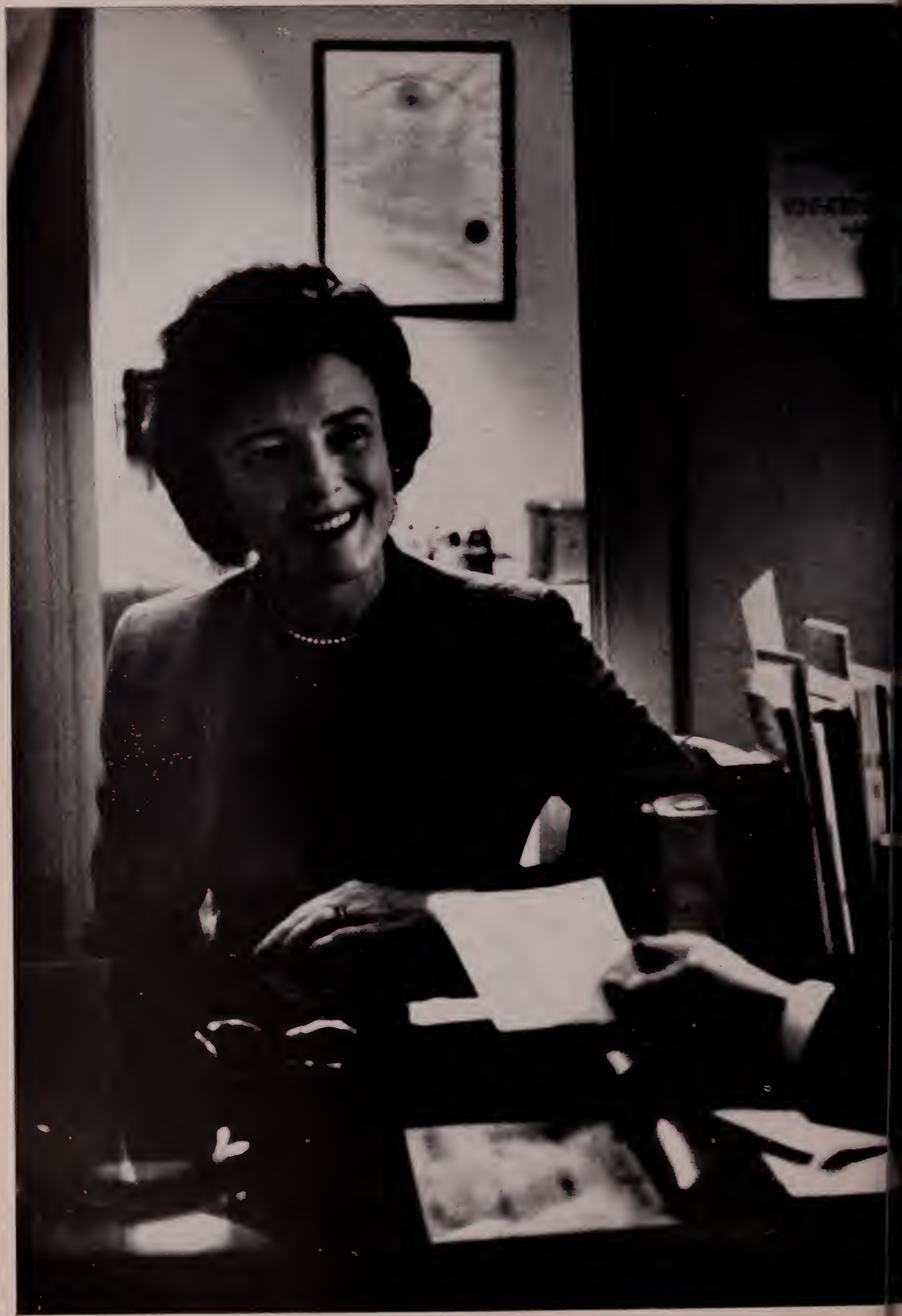
We specialize exclusively in a complete line of RICE DIET baked products for those on salt and fat restricted diets.

All of our products are Laboratory analyzed.

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P. O. Box 282 Durham, N. C.

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"Much better– thank you, doctor"

Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

4. More rapid clinical response
5. Unexcelled toleration

COSA-TETRACYN*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.
(for pediatric or long-term therapy)

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.)
2 oz. bottle

NEW! PEDIATRIC DROPS
(orange-flavored) 5 mg. per drop, calibrated dropper, 10 cc. bottle

COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

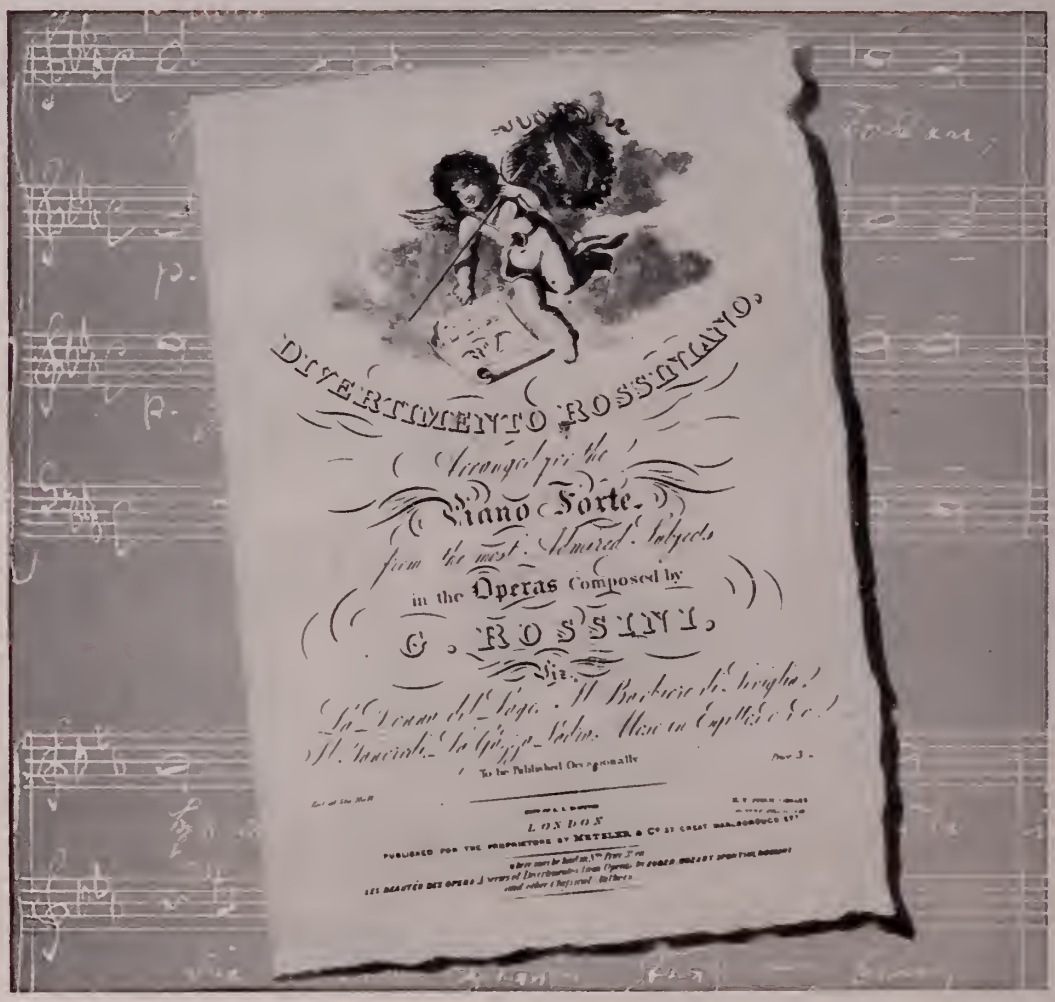
CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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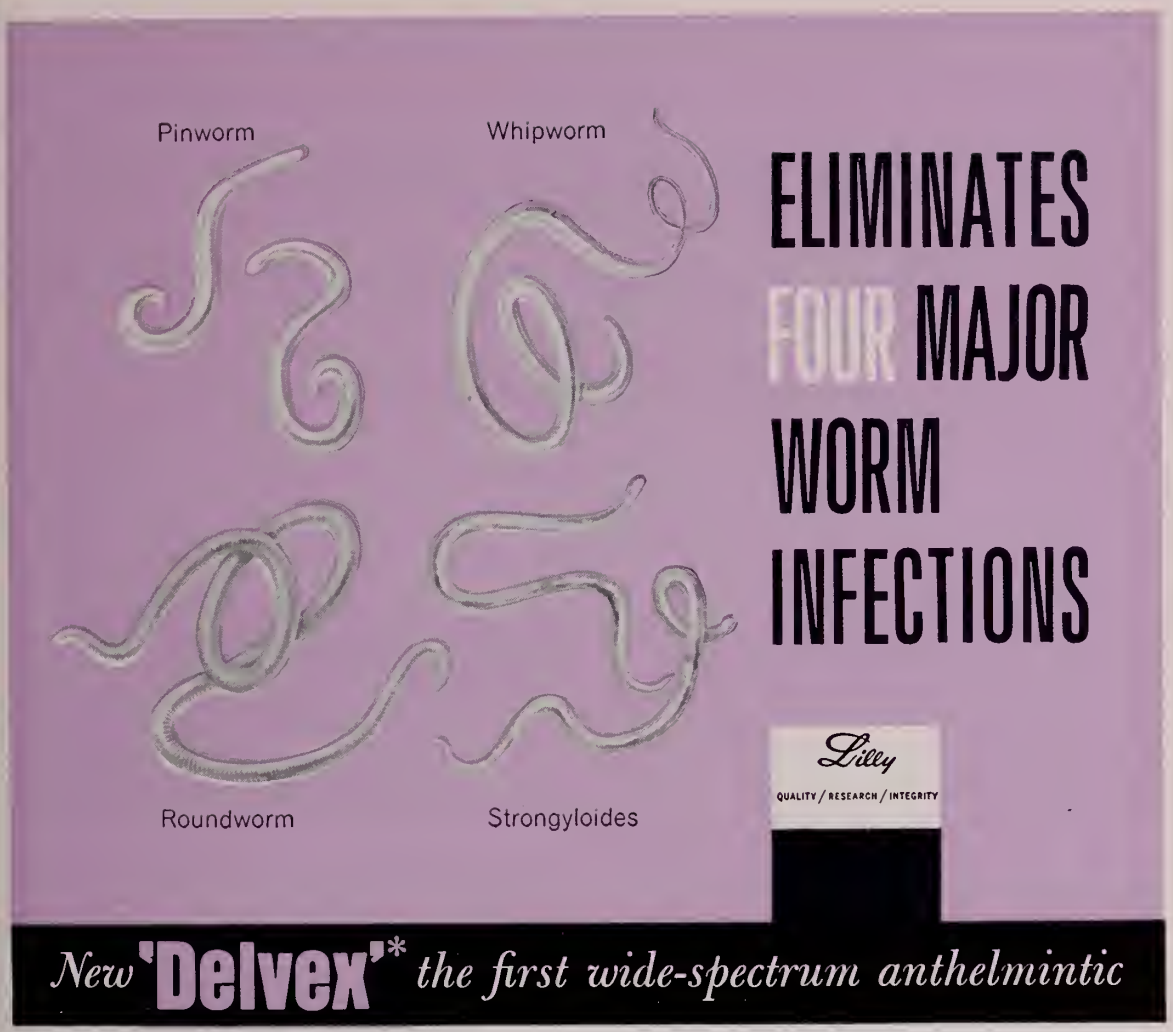
The great operatic works of Rossini have been enjoyed by millions for many decades

THINGS THAT ENDURE

Good things endure . . . a work of art, a literary classic, a proud bridge . . . a dependable pharmaceutical. Such is **Desitin Ointment.** For over 35 years Desitin Ointment has endured as an incomparable, safe way to prevent and clear up diaper rash . . . and as a soothing, healing application in wounds, burns, external ulcers and other skin injuries.

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Clinical studies[1] *show:*

- 'Delvex' is effective orally, usually within five days, against four of the five most common worm infections:

Pinworm	Whipworm
Roundworm	Strongyloidiasis

- It also inhibits, and sometimes eliminates, hookworm infection.
- It is fully effective in both single and multiple infections and in both heavy and light infections.
- It eliminates pinworm infection in 100 percent of patients.
- It is the first effective and practicable agent for the oral treatment of strongyloidiasis and whipworm infection.
- No adjunctive measures are needed with 'Delvex' therapy.

Further information and clinical reports may be obtained from your Lilly representative or by writing to our Medical Department.

*'Delvex' (Dithiazanine Iodide, Lilly)
1. Swartzwelder, J. C., et al.: J. A. M. A., 165:2063, 1957.

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Mazola® Corn Oil...a palatable food effective in the management and control of serum cholesterol levels

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal... high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.



MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

CORN PRODUCTS REFINING COMPANY



nasal and paranasal congestion and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

Oral Decongestant Action. Through the action of Triaminic, nasal patency is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered *orally,* there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

Wide-Spectrum Action. Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

Trisulfaminic *tablets and suspension*

TRIAMINIC PLUS TRIPLE SULFAS

Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic®	25 mg.
(phenylpropanolamine HCl	12.5 mg.;
pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulfapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

(Continued from page 703)

Serving on the committee in charge of the program were Dr. Biel and Drs. Harvey C. Pauley Jr. and John A. Shively, both from Bradenton.

Marion

The Marion County Medical Society has paid 100 per cent of its state dues for 1958.

Orange

The first Doctor-Lawyer Party in Orange County was held the middle of September at the Studio Club in Winter Park. Some 150 persons attended the event jointly sponsored by the Orange County Medical Society and the Orange County Bar Association. Dr. Robert W. Young, of Orlando, was chairman of the committee on arrangements.

Although this was the first formal meeting of physicians and attorneys, committees from both organizations have been meeting to discuss mutual problems. Several months ago a Code of Cooperation was drawn up and accepted by both the medical society and the bar association.

The generally expressed opinion about the party indicates that the doctor-lawyer dinner should become an annual event.

At the Society's September meeting, Mr. Dave Starr, Sheriff of Orange County, discussed "Cooperation Between Orange County Medical Society and Orange County Sheriff's Department." A feature of the October meeting was the Grand Rounds film "Highlights of the AMA Meeting."

Pinellas

The Pinellas County Medical Society has paid 100 per cent of its state dues for 1958.

Pasco-Hernando-Citrus

Drs. Jere W. Annis, of Lakeland, Marion W. Hester, of Lakeland, and H. Phillip Hampton, of Tampa, were principal speakers at the October meeting of the Pasco-Hernando-Citrus County Medical Society held at the home of Dr. S. Carnes Harvard in Brooksville. Dr. Annis is President of the Florida Medical Association; Dr. Hester is Councilor for the Association's Sixth Medical District and Dr. Hampton is chairman of the Association's Committee on Legislation and Public Policy.

Volusia

The Volusia County Medical Society has paid 100 per cent of its state dues for 1958.

Of course,  *women like "Premarin"*

Therapy for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

Doctors, too, like "Premarin," because it really relieves the symptoms of the menopause. It doesn't just mask them – it replaces what the patient lacks – natural estrogen.

"PREMARIN"®
conjugated estrogens (equine)

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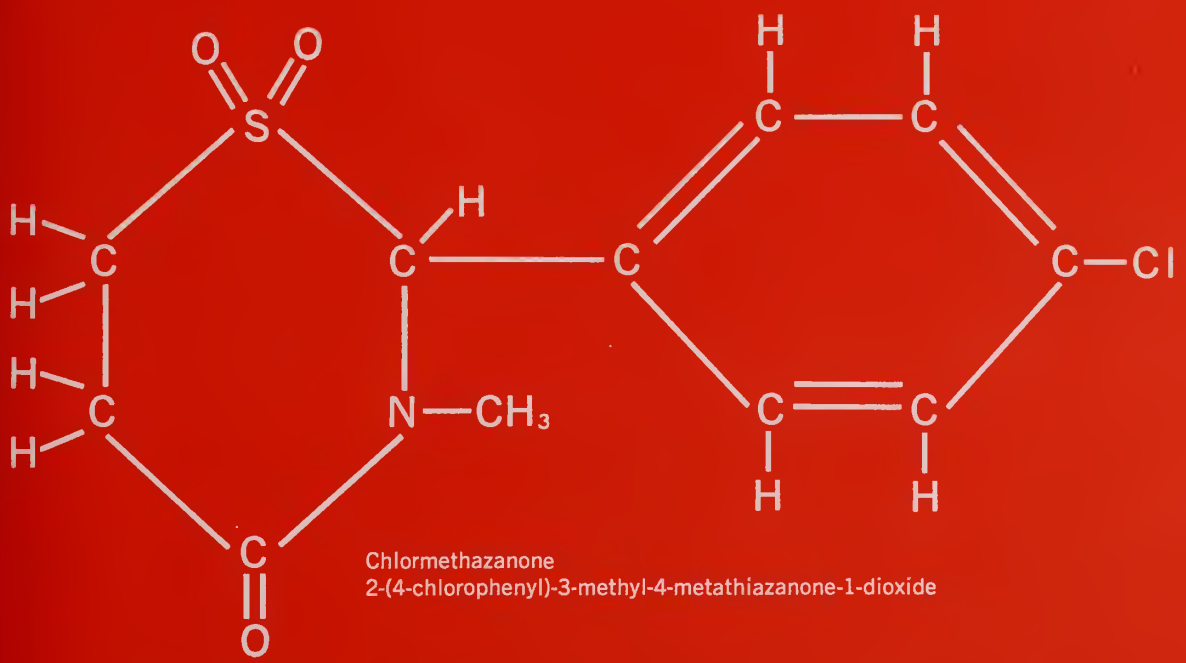
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Winthrop Laboratories
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Tancopal

BRAND OF CHLORMETHAZANONE

a completely new major chemical contribution to therapeutics



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

unrelated chemically to any other drug in current use

designed to be equally effective as both

a MUSCLE RELAXANT

a TRANQUILIZER

Trancopal

*the first true "TRANQUILAXANT"**

offering new freedom for your patients... from muscle spasm, from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'san
[< L. tranquillus, quiet; L. laxare, loosen, as the muscles]

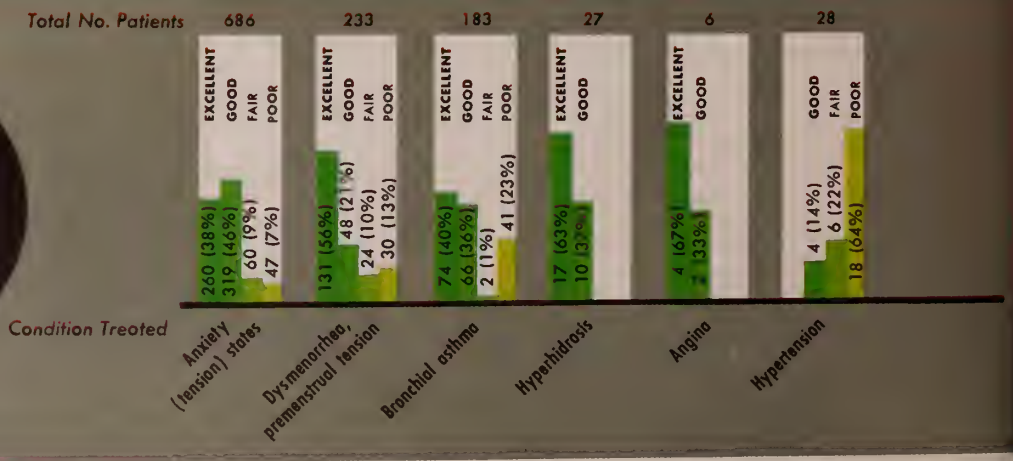
EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtmar

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective whe other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.

TRANCOPAL
IN MUSCULOSKELETAL DISORDERS



TRANCOPAL
IN PSYCHOGENIC DISORDERS



ANCOPAL . . . the first true "tranquilaxant"

Bh a muscle relaxant and a calmative agent.

musculoskeletal disorders, 91 per cent effective.

anxiety and tension states, 93 per cent effective.

ver incidence of side effects than with zoxazolamine, thocarbamol or meprobamate.

known contraindications. Blood pressure, pulse e, respiration and digestive processes unaffected therapeutic dosage. No effects on hematopoietic tem or liver and kidney function.

w toxicity. In animals, even less toxic than aspirin.

gastric irritation. Can be taken before meals.

clouding of consciousness, no euphoria or pression.

perceptible soporific effect, even in high dosage.

CLINICAL RESULTS IN 4092 PATIENTS



MUSCULOSKELETAL CONDITIONS
2929 Patients

+



PSYCHOGENIC CONDITIONS
1163 Patients

=



TOTAL 4092 Patients

MAJOR IMPROVEMENT
84%

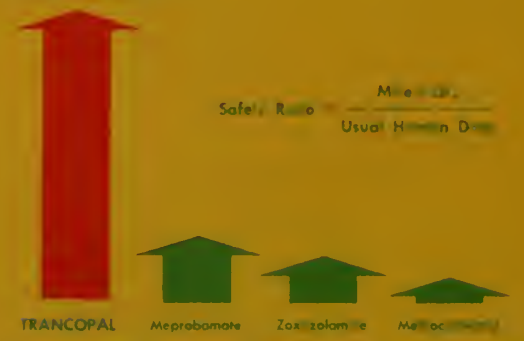
Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY



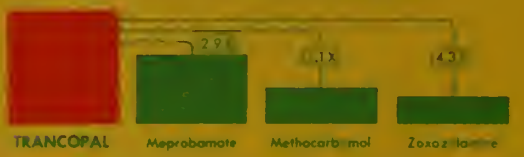
Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

Trancopal

the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

Winthrop Laboratories • New York 18, N. Y.

• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Consolazio, A. R.: J. Pharmacol. & Exper. Therap. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Silvestrini, A. R.; Webb, W. G., and Gesler, R. M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

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New vitamin-mineral supplement
in delicious chocolate-like nuggets



There's nothing easier to give
or take–
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

Each nugget contains:

Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*USP UNITS †INT UNITS

Dose: One Nugget per day
Supplied: Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.

Miles

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KENILWORTH, N. J.



Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

VALENTINE Company, Inc.
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GENERAL PRACTITIONER: To join two young General Practitioners in growing 3 year old practice. Small community, north Florida. Modern 30 bed community hospital adjacent to office. Time off for postgraduate study. Write 69-289, P.O. Box 2411, Jacksonville, Fla.

ULTRA DESIRABILITY: Nine room professional suite. 1000 square feet or less. 503 West Platt, Tampa. Phone 8-1600, 8-1686.

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WANTED: General Practitioner to associate with same. Clinic, hospital suburban Jacksonville. Available Jan. 1, 1959 or July 1, 1959. $15,000 guarantee plus percentage. Probably $20,000 to $25,000 net first year. Preference for general ability, experience, training, personality and permanence. Write 69-277, P.O. Box 2411, Jacksonville, Fla.

New York Physician retiring to Florida Southeast coast in near future. Desires part time position—Institution—Aged—Nursing, etc. Graduate P & S Columbia 1921. For contact phone N.Y. Bayside 9-8960—Reverse charges. Call between 8-9 a.m.

FOR SALE: Doctor's office and established lucrative General Practice in West Palm Beach, Fla. Fully equipped, air-conditioned office with two waiting rooms and six examining rooms; intercom, music, all modern equipment. 200 M. A. X-ray machine and refrigerated tank, dark room BMR, ultratherm, etc. Available immediately to responsible person, because of illness. Write Mr. Kirk Sullivan, P.O. Box 2470, West Palm Beach. Telepbone TEmple 2-8106.

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FLORIDA

Three-five years experience—new modern metal fabrication plant; 5500 employees, continuously expanding. Located in pleasant Florida City. Prefer young man with some industrial or similar military experience; knowledge of internal medicine and diagnosis. Require man with ability to establish and direct medical program and supervise staff of nurses. Current Florida license required. Salary open.

Write 69-292
P. O. Box 2411, Jacksonville, Fla.

PREVENT
both cause and fear of
ANGINA ATTACKS

proven safety for long-term use



Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

+

sustained coronary vasodilation with **PETN** — pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 13F

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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®WALLACE LABORATORIES, *New Brunswick, N. J.*

*TRADE-MARK



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aker, Charles M., Titusville
Bendeck, Taufick E., West Palm Beach
Carney, Robert T., St. Petersburg
Cimino, Louis E., Tampa
Clifford, Samuel L., Pensacola
Driskell, Melville M., St. Petersburg
Eney, Irving P., Miami
Fontaine, Catherine S., Coral Gables
Funderburk, Eugene E. Jr., Lake Worth
Gibby, John F., Miami
Graybill, Robert E., Hollywood
Jahn, Robert J., Winter Haven
Johnson, Lawson C., Miami
Leonard, Paul C., Dunedin
Molina, Antonio E., Miami
Mortimer, Raymond E., Redington Beach
Rogers, Robert J., Eau Gallie
Rundles, William R., Pensacola
Vinson, Cilfford E., Fort Myers
Walker, Gilbert H., Coral Gables
Webb, Edgar W., Miami
Worley, Lee M. II, Miami

OBITUARIES

Samuel Bernard Kleinman

Dr. Samuel Bernard Kleinman of Miami Beach died on July 18, 1958, of chronic granulocytic leukemia. He was 44 years of age.

Born in Russia on Jan. 3, 1914, Dr. Kleinman came to the United States with his mother when he was five months of age. He received his elementary education in the public schools of Chicago and at the Marshall High School, which awarded him a three year scholarship on graduation. After receiving the Bachelor of Science degree at the University of Chicago, he obtained his professional training at Rush Medical College, where the degree of Doctor of Medicine was conferred upon him in 1938. After completing internships at Municipal Contagious Hospital of Chicago and Cook County Hospital, he served residencies at veterans' hospitals in Minneapolis, Minn., and Excelsior Springs, Mo.

During World War II, Dr. Kleinman served in the Medical Corps of the United States Army with

(Continued on page 718)



Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."

Alglyn®

Dihydroxy aluminum aminoacetate, N.N.R.

In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

BRAYTEN PHARMACEUTICAL COMPANY • *Chattanooga 9, Tennessee*



The Upjohn Company, Kalamazoo, Michigan


ake new
Panalba*
nycin Phosphate plus Albamycin**)
our
road-spectrum
ntibiotic
first resort
fective against more
an 30 common pathogens,
en including
sistant staphylococci.
forms:
Capsules, bottles of 16 and 100
Each capsule contains:
phosphate (tetracycline phosphate
equivalent to tetracycline hydro-
250 mg.
(as novobiocin sodium) 125 mg.
KM Flavored Granules When
water is added to fill the bottle,
teaspoonful (5 cc.) contains:
(tetracycline) equivalent to tetra-
hydrochloride 125 mg.
(as novobiocin calcium) 62.5 mg.
metaphosphate 100 mg.
Capsules
dosage is 2 capsules q.i.d.
KM Granules
treatment of moderately acute infec-
in infants and children, the recom-
dosage is 1 teaspoonful per 15 to
of body weight per day, administered
equal doses. Severe or prolonged
require higher doses. Dosage for
to 4 teaspoonfuls 3 or 4 times d
on the type and severity of the in-

(Continued from page 714)

the rank of major and was stationed at Alexandria, La. He was granted an honorable discharge in May 1946.

In April 1946 Dr. Kleinman joined his father, Dr. Bernard S. Kleinman, in the practice of medicine in Miami Beach. He was an expert and adept physiatrist and owned the Dade Institute of Physical Medicine and Rehabilitation at Miami Beach. Locally, he was a member of Temple Beth Sholom.

Dr. Kleinman was a member of the Dade County Medical Association. He also held membership in the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Thelma Kleinman, a daughter, Sara, two sons, Joel and Paul, and his father, Dr. Kleinman, all of Miami Beach.

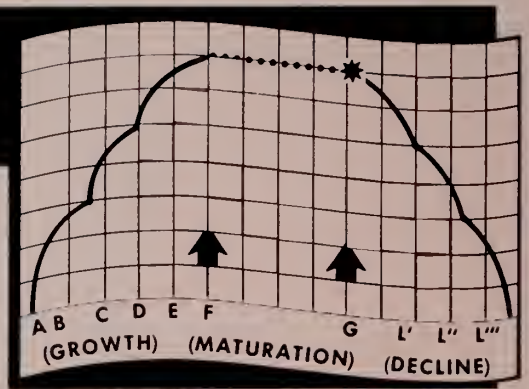
Marion Childress Wilson

Dr. Marion Childress Wilson died at his home in Miami on Sept. 13, 1958, of Parkinson's disease following a long illness. He was 72 years of age. Funeral services were conducted at Fayetteville, Tenn., on Sept. 17, 1958, with interment in the family plot at Boonshill, Tenn.

Born on April 5, 1886, at Boonshill, Dr. Wilson was the son of A. B. and Mary White Wilson. He was educated in his native state and received both his academic and his medical training at Vanderbilt University, where he was awarded the degree of Doctor of Medicine by the School of Medicine in 1912. From 1912 to 1914 he interned at Riverside Hospital in New York City and Jersey City Hospital in Jersey City, N. J. He was resident surgeon at Lawrence Hospital in Bronxville, N. Y., in 1915 and at Woman's Hospital in New York City in 1916. During World War I he was a captain in the Medical Corps of the United States Army for 18 months and served at City Hospital, Allentown, Pa. From 1918 to 1920 he was a missionary hospital surgeon in Marash, Turkey, with the Near East Relief. After serving as Associate Professor of Obstetrics and Gynecology for three years at Vanderbilt University School of Medicine, Dr. Wilson located in Miami in 1926. He was Chief of Obstetrics at Jackson Memorial Hospital that year. From 1929 to 1947 he was Chief of Obstetrics at St. Francis Hospital in Miami Beach, where in 1947 he was a member of the executive committee and became Chief Emeritus in Obstetrics. Locally, he was a Mason, a

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For potients over 40, The G POINT (point of declinotion in life) con be postponed!

Properly bolonced Androgen — Estrogen — nutritionol theropy moy prevent premoture aging ond domage of gonadol decline and nutritionol inodequocy.

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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...from mild pain complicated by tension and restlessness.

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Shriner and a Rotarian. He held membership in the Shenandoah Presbyterian Church.

Dr. Wilson was a member of the Dade County Medical Association and the Florida Medical Association. He was a fellow of the American Medical Association and a member of the Southern Medical Association and of the National Malarial Association. Prominent in his specialty societies, he was one of the founders of the South Atlantic Association of Obstetricians and Gynecologists and was a charter member and first president of the Miami Obstetric and Gynecologic Society.

Survivors include the widow, Mrs. Frances Weaver Wilson, of Miami; and three daughters, Mrs. Harry Horn, of Lake George, New York, Mrs. Robert H. Sharp, of Miami, and Mrs. Robert Poorbaugh, of Orlando. Two brothers, two sisters and five grandchildren also survive.

Douglas Dickinson Martin

Dr. Douglas Dickinson Martin of Tampa died unexpectedly of a heart ailment at St. Joseph's Hospital on May 24, 1958. He was 68 years of age.

The son of William H. and Jane Dickinson Martin, Dr. Martin was born in Gordonsville, Va., on Jan. 16, 1890. He received his academic schooling at the Virginia Polytechnic Institute, where he was graduated in 1909, and his medical training at the Medical College of Virginia, where he was awarded the degree of Doctor of Medicine in 1913.

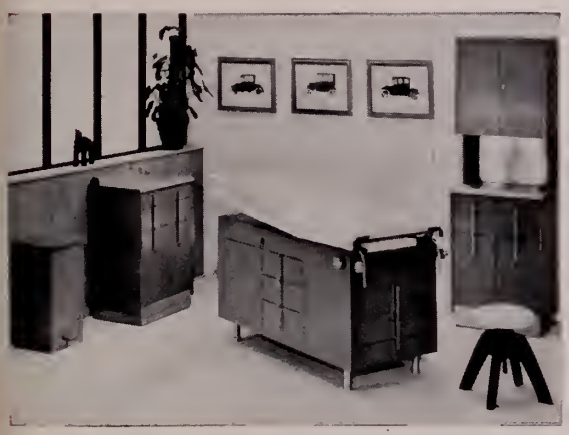
In World War I Dr. Martin served as an officer in the Navy. In 1942 he re-entered the Navy and during much of World War II he was with a fleet hospital traveling with invasion forces making assaults on Japanese-held islands. Later he was chief of medical service of the Navy hospital at Dublin, Ga., and retired with the rank of commander in the United States Naval Reserve.

Dr. Martin came to Florida from New York City in 1922 and entered the practice of medicine in Tampa. A pioneer pediatrician in the state, he won distinction early in his career as a leader in his specialty throughout Florida and the South. Soon after locating in Tampa, he founded the Tampa Children's Hospital. Since 1935 he had been chief of the Department of Pediatrics at St. Joseph's Hospital. Locally, he was a member of

(Continued on page 726)

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By *Hamilton*



Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere—and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basis and pull-out step are included.

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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

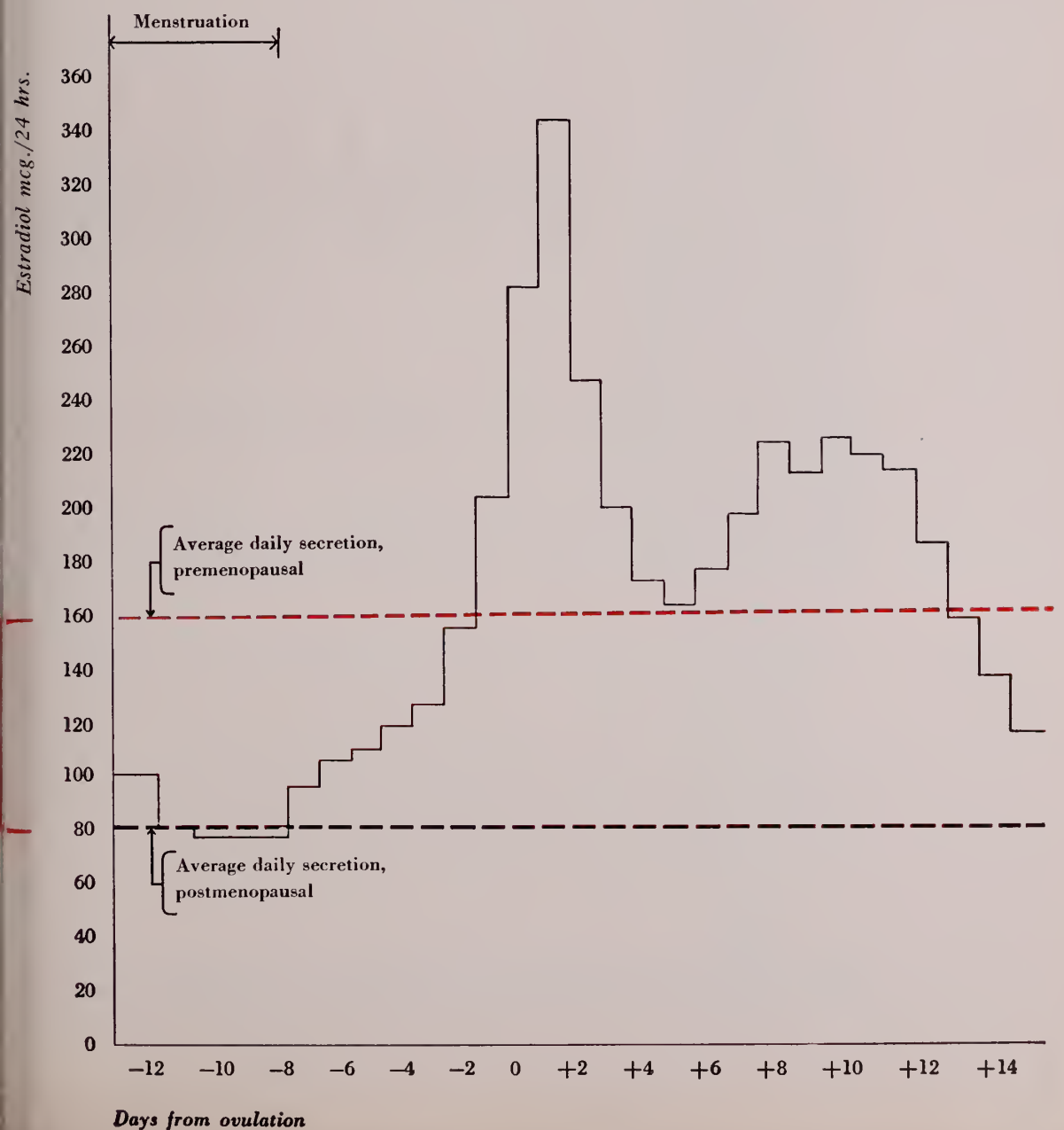
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

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Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion of estradiol, estrone, and estriol)



to relieve edema o

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166:141,** Jan. 11, 1958.

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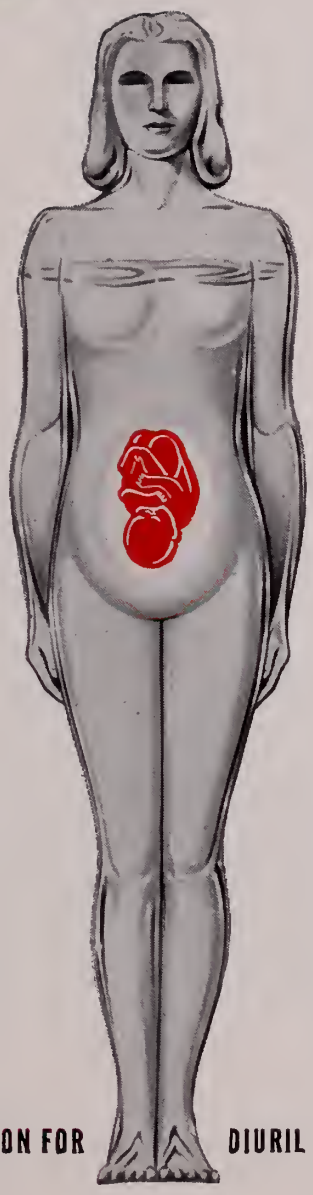
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1958 Conference and Fall Board Meeting

There was little doubt in anyone's mind as to the success of the 1958 Conference and Fall Board meeting held October 21-22 at the Whitehall Hotel in Daytona Beach. The feeling of enthusiasm was in evidence in every face. Time was at a premium with so much to be said and things to be accomplished. We regret more time had not been allocated to this conference and we departed reluctantly when it ended. A lovelier and more capable group of ladies could not be found anywhere than those present representing the Auxiliaries from all over the state of Florida.

We had an outstanding group of men with us during our meeting, beginning with Dr. Jere W. Annis, Lakeland, President of the Florida Medical Association, who spoke briefly to us about the importance of our work in connection with the work of the Association and stated that "when looking around for people to lean on and get things done," he counted strongly on the women of the Auxiliary.

"Florida Medical Association Foundation, Its Programs, Plans, and Policies," was presented by Dr. Edward Jelks, Jacksonville, President of the Foundation. He was introduced as the "Dean of Medicine in Florida" and his 'know how' of everything going on in medicine would convince one that he wears his title well. He listed some of the projects of the Foundation as:

1. Furnishing financial aid to medical students
2. Scientific knowledge through Public Relations
3. Medical Education and Medical Ethics
4. Financial assistance for retired doctor's families

Explanation of the Florida Medical Association Disability Income Protection and Catastrophe Hospital-Nurse Protection Programs were subjects presented by Mr. Leyton Hunter of Marsh



Attending the Conference and Fall Board meeting of the Woman's Auxiliary to the Florida Medical Association were (back row, left to right) Mrs. Jere W. Annis, Lakeland; Dr. Edward Jelks, Jacksonville, President, Florida Medical Foundation; Dr. Jere W. Annis, Lakeland, President, Florida Medical Association; Dr. Louis M. Orr, Orlando, President-Elect, American Medical Association; Dr. Willard E. Manry Jr., Lake Wales, Member, Florida Medical Association Advisory Committee to Auxiliary; Mrs. Louis M. Orr, Orlando; Mrs. Richard Stover, Miami, First Vice President, Woman's Auxiliary to the American Medical Association, and Mr. W. Harold Parham, Jacksonville, Executive Director, Florida Medical Association. (Front row, left to right) Mrs. Lee Rogers Jr., Rockledge, President, Woman's Auxiliary to the Florida Medical Association; Mrs. Wendell J. Newcomb, Pensacola, President-Elect, Woman's Auxiliary to the Florida Medical Association, and Dr. Achille A. Monaco, Daytona Beach, President, Volusia County Medical Society.

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The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

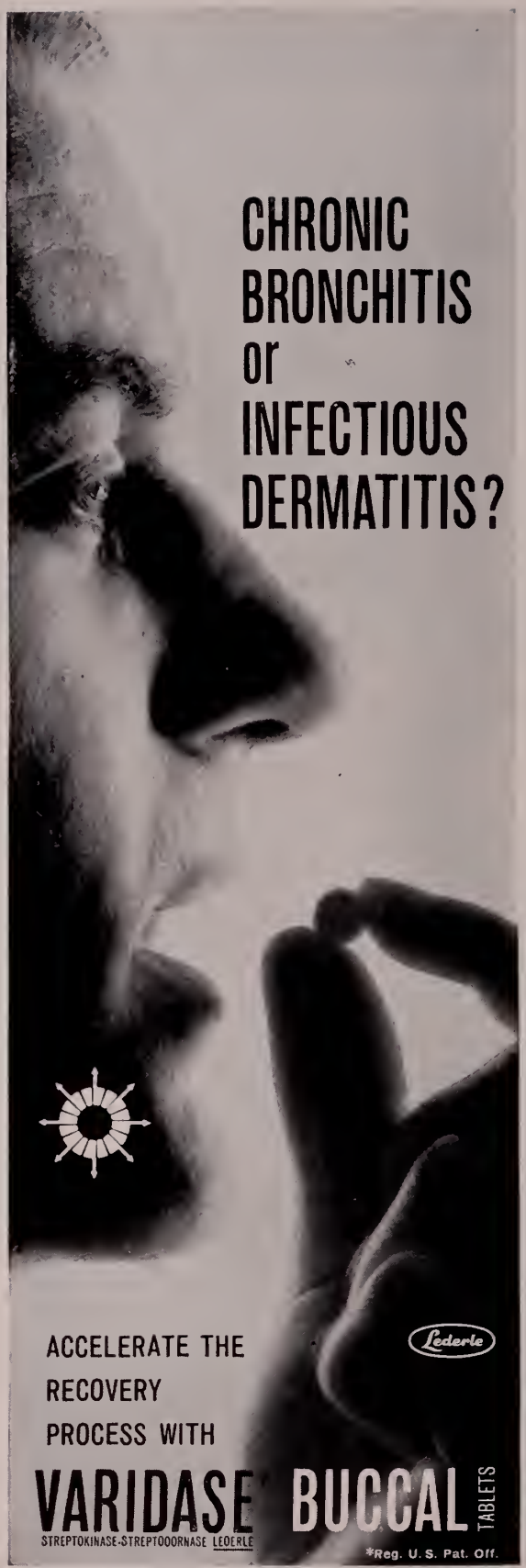
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and McLennan of Atlanta, Ga. Mr. Hunter stated that there are still 2400 physicians in the state who are not participating in this program and urged each wife to go home and talk over this plan with her husband. The Florida Medical Association Insurance Plan was developed two years ago and one of the advantages is insuring income and family against serious hospital expense. This program certainly warrants further study by those who have not looked into it.

Auxiliary members were also introduced to Mr. W. Harold Parham, of the Executive Office in Jacksonville.

A fitting climax to our meeting was the presentation of Dr. Louis M. Orr as luncheon speaker. He discussed the plans of the American Medical Association for the year and listed three of the important programs as follows:

1. Quackery
2. Health Care of the Aging
3. Third Party vendors of Medical Plans

Along with his speech he used props to demonstrate each point which were amusing as well as interesting. We are proud of Dr. Orr and know that he will do great things for the American Medical Association.

Other luncheon guests included Dr. Achille A. Monaco, Daytona Beach, President, Volusia County Medical Society, and Dr. Willard E. Manry, Lake Wales, member of the State Advisory Committee to the Auxiliary. We are grateful for their interest in our current projects and for the work which we hope to accomplish.

Mrs. Albert F. Stratton, Jr.

(Continued from page 719)

the Greater Tampa Chamber of Commerce, the Tampa Yacht and Country Club and Ye Mystic Krewe of Gasparilla. He was a communicant of St. Andrews Episcopal Church.

A member of the Hillsborough County Medical Association, of which he was a past president, Dr. Martin was also a member of the Florida Medical Association for 35 years. He held membership in the American Medical Association, the Southern Medical Association and the American College of Physicians. He was active in the American Academy of Pediatrics and other societies of his specialty and was a diplomate of the American Board of Pediatrics.

The widow, Mrs. Mary Chancellor Martin, of Tampa survives. Also surviving are a son, Douglas D. Martin Jr., of Tampa; two daughters, Mrs.

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A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

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PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

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REFERENCES:
1. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958.
2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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Pearl River, New York

Eugene H. Pillsbury, of Bonn, Germany, and Mrs. John L. Dugan, of Louisville, Ky.; three sisters, Mrs. J. C. Dickinson, of Tampa, Mrs. Lutie Davenport, of Richmond, Va., and Mrs. O. W. Johnson, of Lynchburg, Va.; and three grandchildren.

BOOKS RECEIVED

The Psychology of Medical Practice. By Marc H. Hollender, M.D. Pp. 276. Price, $6.50. Philadelphia, W. B. Saunders Company, 1958.

In a general way the author uses the expression, the psychology of medical practice, in this book to refer to the art of medicine. He turns the psychologic spotlight on the patient, the physician and what might be called the medical situation. He explains that although the problems which may arise in connection with one or another specific illness are considered, even in some detail, it is his intention not to provide cookbook-like recipes but rather to evolve principles and to illustrate an approach. At times the discussion may shift from a consideration of conscious difficulties which can be understood at a common sense level to unconscious problems which require some knowledge of psychiatry. The emphasis remains, however, on the problems encountered in the everyday practice of medicine and what can be done about them. The book is not a textbook of psychiatry, nor is it a textbook of the so-called psychosomatic approach to medicine or psychosomatic medicine. The focus is maintained on those psychologic problems encountered in practice which the physician will attempt to handle himself.

Four specialties—medicine, surgery, obstetrics and pediatrics—to which most time is usually alloted in the medical school curriculum are singled out for special consideration. A separate chapter is devoted to the patient with carcinoma. Two chapters focus on the doctor-patient relationship, one theoretical and the other practical. Here is a practical approach to a timely subject, giving helpful answers to such difficult questions as: Why does a patient fail to take prescribed medication? What should you tell a patient and his family about his illness? What are the problems of the juvenile diabetic? What do you tell a patient when you do not tell him he has cancer? When should you tell a patient about the operation he needs? The effects of the physician's attitude upon the patient are shown throughout the book.

Callander's Surgical Anatomy. By Barry J. Anson, M.A., Ph.D. (Med. Sc.), and Walter G. Maddock, M.S., M.D., F.A.C.S. Ed. 4. Pp. 1157. Illus. 1047. Price, $21.00. Philadelphia, W. B. Saunders Company, 1958.

This fourth edition of this classic should prove invaluable to every physician who performs surgery, whether he be surgeon, intern, resident, specialist or general practitioner. This atlas of living anatomy will orient him anatomically for any operation he may be called upon to perform. The structure of the organs of each region of the body is carefully described and illustrated, and the surgical applications of this anatomy are clearly stated. The authors point out surgical landmarks, anatomic variations, possible involvements, operative approaches and cautions, plus actual step-by-step technic. There are more than 1,600 illustrations on 1,047 figures, of which 275 were added for this edition. These new illustrations and new text throughout the book bring the work completely in line with today's thought in anatomy and with today's practice of surgery. New information is included on the anatomy of abdominal, thoracic and pelvic organs.

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Composition: 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

Dosage: 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

Supplied: Bottles of 100 capsules and 12 oz. of suspension.

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Fine Pharmaceuticals Since 1894

Diabetes as a Way of Life. By T. S. Danowski, M.D. Pp. 177. Price, $3.50. New York, Coward-McCann, Inc., 1958.

This practical, helpful, and reassuring guide by a leading authority gives the diabetic the necessary knowledge and confidence to enable him to live with diabetes successfully. The author covers the various factors affecting the life of the diabetic and answers the many questions that are sure to arise. The book is comprehensive in its scope yet never overly technical, and gives the diabetic all the information that he needs and would want to know. By explaining the nature of diabetes and its care and treatment, Dr. Danowski, who is Renziehausen Professor of Research Medicine at the University of Pittsburgh, gives the diabetic the knowledge, understanding and confidence to enable him to lead a normal, useful and healthy life.

Dr. Danowski discusses what diabetes is, showing the role of the doctor, the family, and the patient in its care and control. There is a chapter on the treatment of diabetes with food, giving suggested diets. The book takes up the administration of insulin and the types available, and it points out the signs and symptoms of satisfactory and unsatisfactory control of diabetes. Acidosis and coma and insulin shock are thoroughly discussed, and the author goes into the social aspects of diabetes. There are separate chapters on diabetes in children and pregnancy in the diabetic. The book includes an appendix which contains more detailed material on some of the subjects mentioned within the book, and there is a glossary of terms for the diabetic.



Correlative Neuroanatomy and Functional Neurology. By Joseph G. Chusid, M.D. and Joseph J. McDonald, M.S., M.Sc.D., M.D. Ed. 9. Pp. 345. Price, $4.50. Los Altos, Calif., Lange Medical Publications, 1958.

This book, now in its ninth edition, is intended for the beginner in neurology and will serve him best if used as an aid or supplement to standard neurologic texts and literature. In recent years it has became popular with practitioners, residents, and graduate physicians preparing for specialty board examinations as a handbook and review of neurology. The primary objective of the authors has been to present simply and clearly some of the structural and functional features of the nervous system related to problems encountered in clinical neurology. Concise format, charts, diagrams, and photographs have been prepared with this purpose in mind. Section I deals with the central nervous system, Section II with peripheral nerves, and Section III with principles of neurodiagnosis.

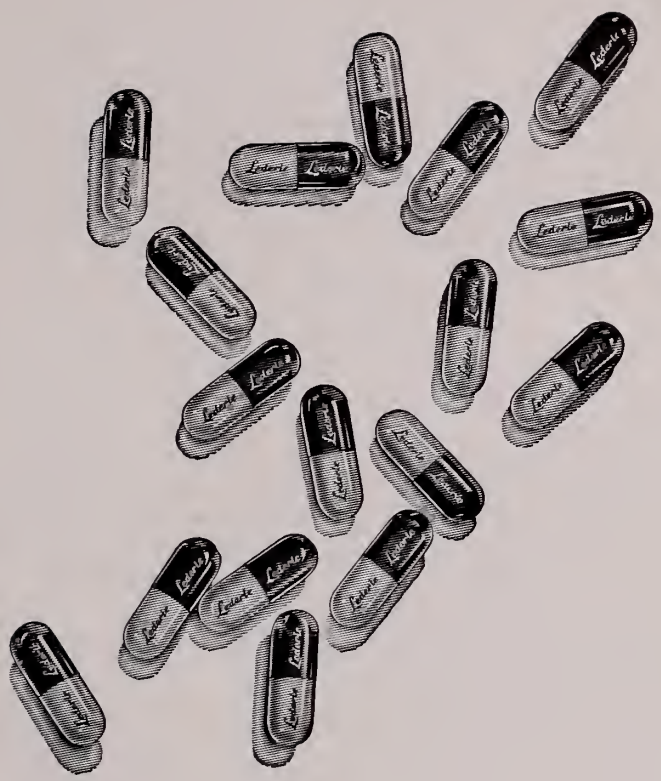
Erythroblastosis Fetalis *including Exchange Transfusion Technic.* By Fred H. Allen, Jr., M.D., and Louis K. Diamond, M.D. Pp. 143. Price, $4.00. Boston, Little, Brown and Company, 1958.

Since the Rh blood factor was first found and its relation to erythroblastosis fetalis established in 1940, a large number of important new blood factors have been discovered. This book serves to clarify all phases of erythroblastosis fetalis—the blood factors that can produce it, the mechanism of production of anemia and jaundice in the newborn, how to protect newborn infants against brain damage, and the proved method of saving the baby by exchange transfusion. A detailed description of the technic of exchange transfusion is included.

(Continued on page 737)



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Speed of absorption adds new emphasis to the benefits of true broad-spectrum action, minimum side effects and wide range effectiveness that have established ACHROMYCIN as an antibiotic of choice for decisive control of infection.

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ACHROMYCIN V dosage; Recommended basic oral dosage is 6-7 mg. per lb. body weight per day. In acute, severe infections often encountered in infants and children, the dose should be 12 mg. per lb. body weight per day. Dosage in the average adult should be 1 Gm. divided into four 250 mg. doses.

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Tetracycline HCl and Citric Acid Lederle

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THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production ... nutrition participates in the prophylaxis against most acute infections ..."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions ... Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

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Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more capsules daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

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References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

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Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
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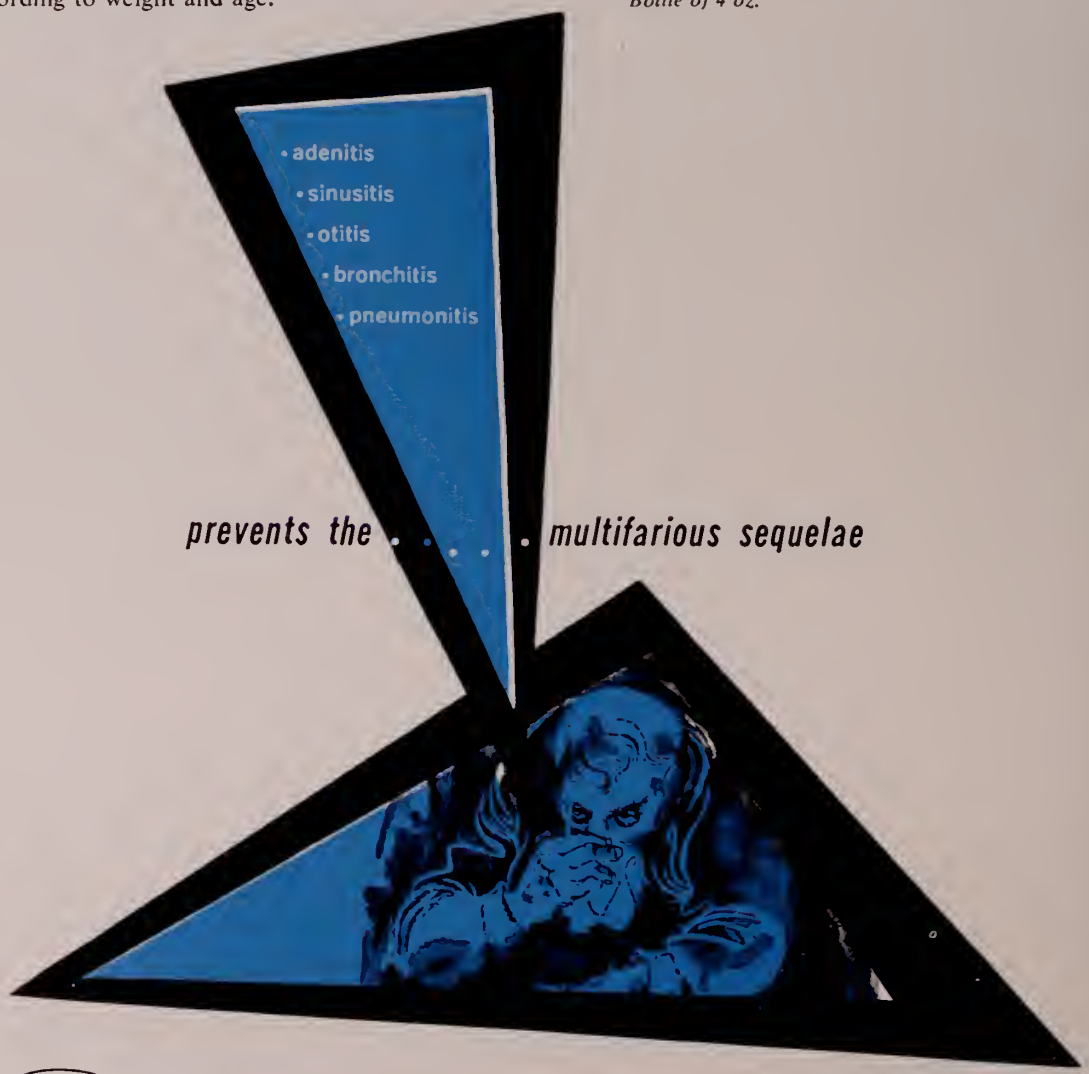
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SYRUP *(lemon-lime flavored)*

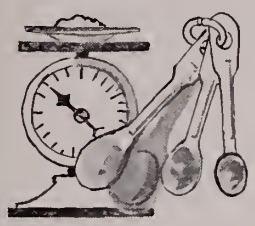
Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.



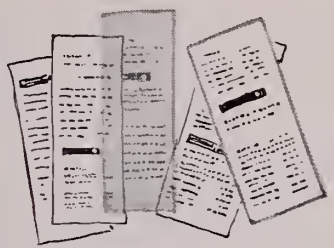
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Measured Amounts



Fitting Casseroles



Food Exchange List



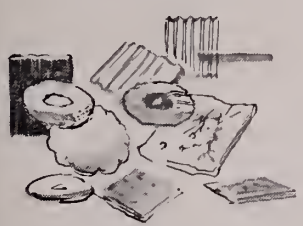
Punctual Meals



Light Snack



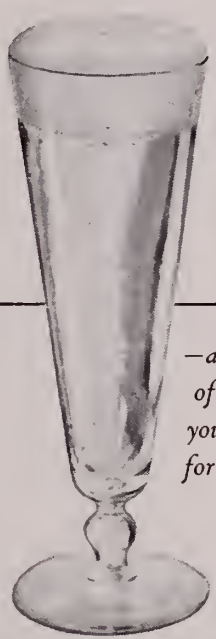
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Low-Calorie Nibbles



Varied Choice



A few suggestions to help the diet fit your patient's personal preferences and way of life

—and a glass of beer, with your consent, for a morale-booster

The Diabetic Diet

A measured diet is vital. Portions should be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect. A food exchange list provides variations in diet. Insulin demands food with the urgency and regularity of an alarm clock.

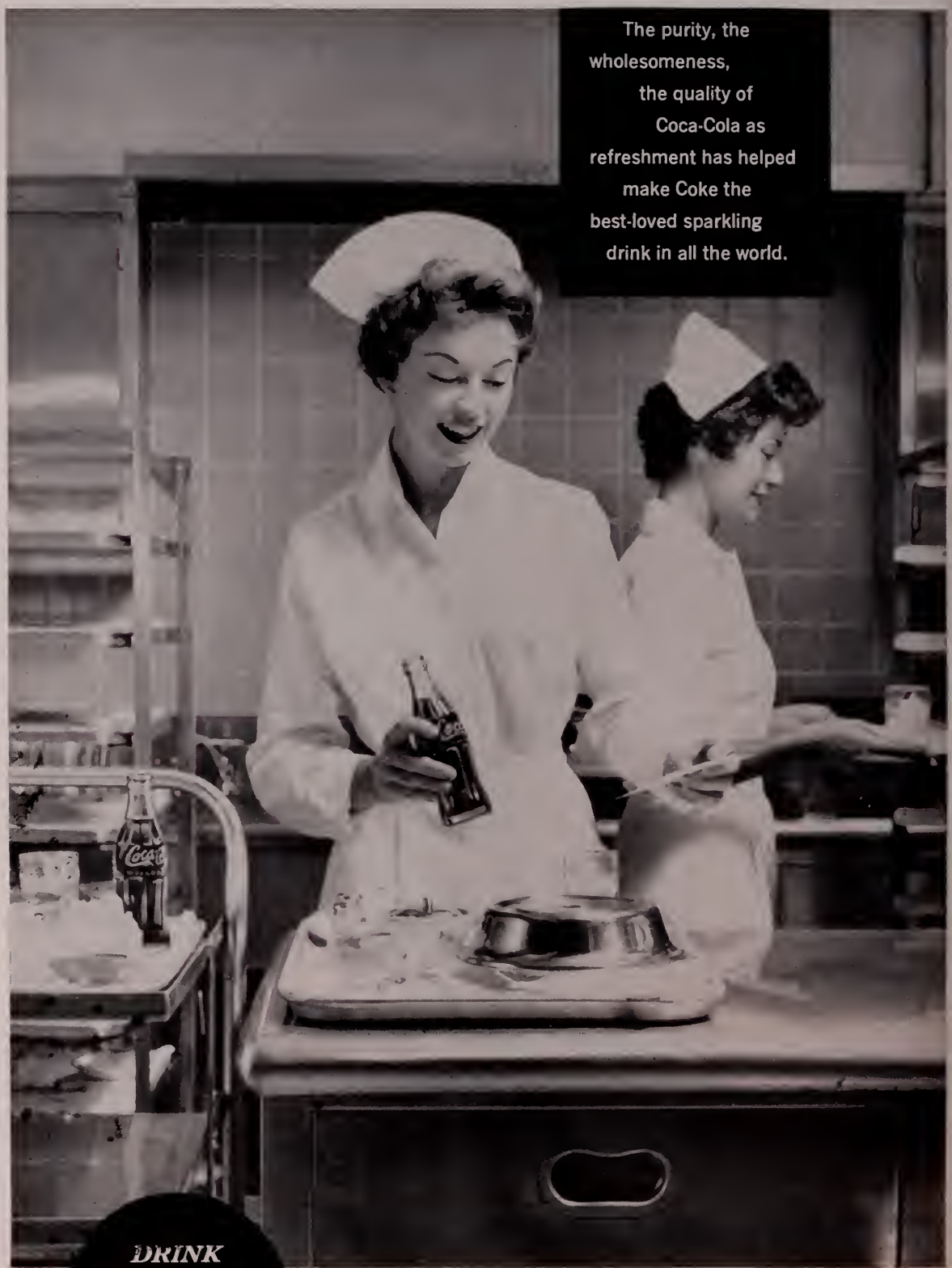
If dinner is late, suggest a light snack at the usual mealtime with corresponding caloric reduction in the delayed meal. Hard candies do well as a precaution against insulin reaction. Plan low calorie wafers when others nibble canapés or chocolates. Above all, give your patient a variety of his food preferences.

And with a glass of beer*—at your discretion—your patient will find his diet interesting and ample without straying from instructions.

*Carbohydrate 9.4 Gm; Protein 0.8 Gm; Calories 104/8 oz. (Average of American Beers)

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(Continued from page 730)

Serologists will find a discussion of the detection and identification of blood group antibodies that may cause erythroblastosis fetalis, and specific data on the diagnostic procedures and the method of selecting blood for exchange transfusion. Obstetricians will find helpful suggestions on prenatal management and on prognosis for subsequent babies. Pediatricians will find much practical information on diagnosis and treatment. This concise yet thorough handbook of theoretical as well as practical points should be helpful to the student of blood group immunology and to all physicians who wish to offer patients the best and most recent advances in the care of erythroblastosis fetalis. This book is one of four books comprising the New England Journal of Medicine Medical Progress Series, most of the material originally appearing in the "Medical Progress" section of that journal in October 1957.

Diagnosis and Treatment of Diseases in the Tropics. By H. C. Trowell, O.B.E., M.D., (Lond.), F. R.C.P. Pp. 332. Price, $3.75. London, Baillière, Tindall and Cox, 1956.

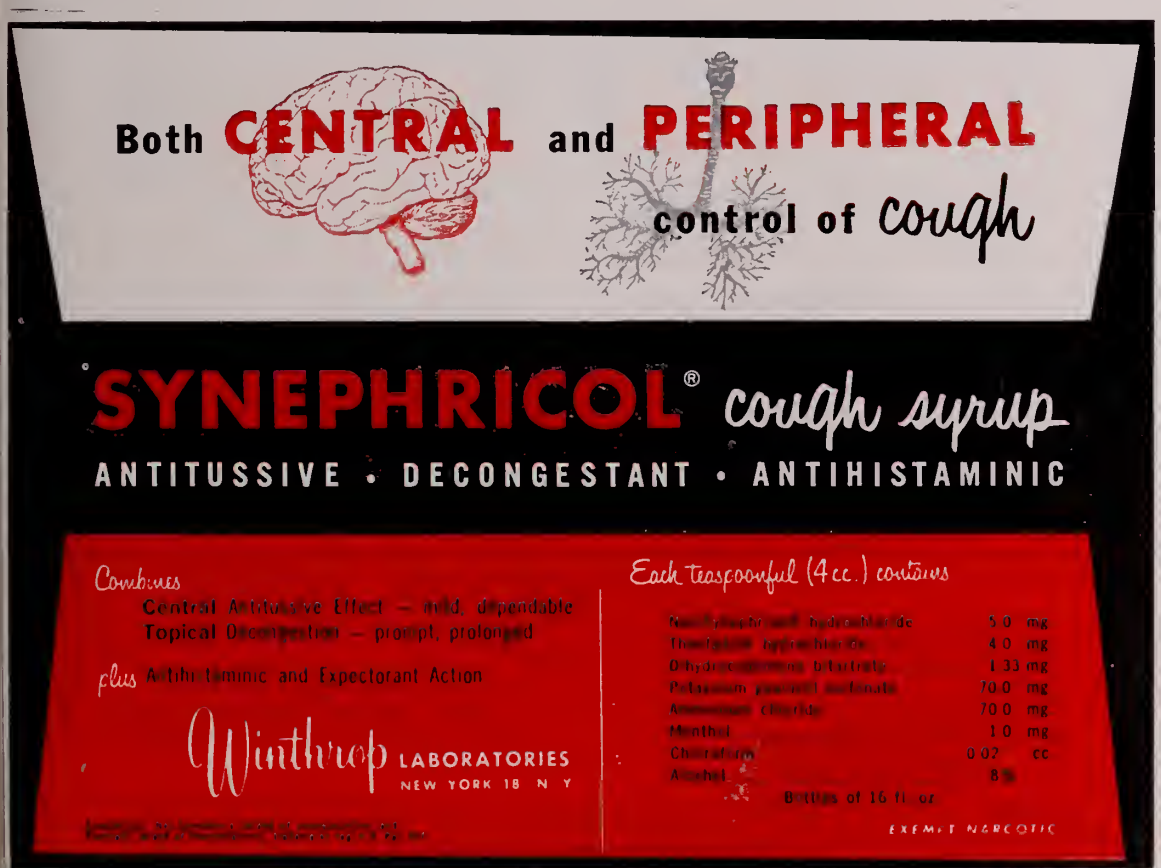
This book serves as a useful introduction to the study of the diseases encountered in tropical countries, especially those of tropical Africa. The number of fully qualified doctors is still very small in many parts of Africa so that the work of diagnosis and treatment must often be undertaken by those who have not had the full training of a doctor, be it nurse, dresser, or indeed any willing and intelligent person. This third edition to be published in 16 years indicates that this pocket size volume meets a real need. It has been extensively revised to include the considerable advances in medical knowledge in recent years.

The author is Senior Specialist at Mulago Hospital, Mulago, Kampala, Uganda, Lecturer in Medicine at Uganda Medical School and formerly, Medical Officer, Training of Africans, Kenya. The book is the third of a series of four books comprising Baillière's Elementary Tropical Handbook Series, originally called Medical Manuals for Africans, all so simply written that they can be used by those whose knowledge of English is somewhat limited. The Williams & Wilkins Co., of Baltimore, are exclusive agents for this series in the United States.

Pediatric Index. *A Guide to Symptomatological Diagnosis and Current Management.* By Edwin F. Patton, M.D. Pp. 639. Price, $13.50. St. Louis, The C. V. Mosby Company, 1958.

This book offers an approach toward alphabetical systemization of pediatric thought and practice designed to assist in providing the best possible care to any child with any problem. It presupposes that the practitioner consulting it already possesses a substantial working fund of medical knowledge which it endeavors to supplement by filling in gaps, preventing oversights, and epitomizing essential facts. It is an assembly job—a compilation of the best available published and practiced material in the field, gathered from any and all authentic sources throughout the world. So states the author in the Preface, and he adds that the book should be particularly useful to general practitioners, students, and less experienced pediatricians, but even "pediatric ivory towers" may be helped in running down obscure diagnoses by scanning the conditions listed under various presenting symptoms.

Section I, Symptomatological Diagnosis, takes up the problem as it confronts the doctor: complaints, symptoms, signs. Section II, Definitive Diagnoses and Current Management, carries on with the problem of proving or disproving the diagnosis which has been selected as most



probable, and what to do about it. Section III, Special Data and Technique, contains, in alphabetical order, materials applicable to several conditions to save repetition under each one, together with some helpful miscellaneous information. Treatment has been selected on a basis of authoritative sources, in conjunction with 35 years of personal experience, whenever applicable.

Ciba Foundation Symposium on the Chemistry and Biology of Mucopolysaccharides. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Maeve O'Connor, B.A. Pp. 328. Illus. 48. Price, $8.50. Boston, Little, Brown and Company, 1958.

This symposium deals with a rapidly developing new field of special interest to pathologists, physiologists, and biochemists. Mucopolysaccharides have been known and studied for several decades, but no generally accepted definition is currently in existence, although most will agree that carbohydrates and amino acids are an integral part of the complex molecule. Last year the Ciba Foundation in London sponsored a conference on mucopolysaccharides to examine the chemical and biologic aspects of this group of substances. The participants brought out the increasing importance of various of these compounds in physiology, pathology and clinical medicine.

The transactions of the conference, here presented, center mainly on four topics: lipopolysaccharides, the chemistry and distribution of sialic acid, blood group substances, and mucopolysaccharides in connective tissue. Within the framework of these fields, contributions cover a group of subjects ranging from pure organic chemical and physicochemical questions to a multitude of biologic problems, including biosyntheses, chemical genetics, serologic reactions, physiologic functions and pathologic phenomena.

The Atomic Age and Our Biological Future. By H. V. Brondsted. Pp. 80. Price, $2.75. New York, Philosophical Library, 1957.

The aim of this book is to describe simply, and with a minimum of technical language, the biologic, and particularly the genetic, effects that may ensue from the increasing use of atomic energy, if rigorous measures are not taken to ensure that the amount of radiation from the atmosphere does not rise above the level that can be tolerated without damage to the human body. It is based on a series of lectures to the general public. There is an account of the structure and behavior of the atom and of the development of the embryo and the mechanisms of heredity. Among the aspects of the problem dealt with are mutations, the transmission of genes, the visible effects of radiation on the body, radiation and sterility, and the use of radioactive isotopes. The author, who is Professor of Zoology at the University of Copenhagen and the author of numerous books on biologic subjects, emphasizes the responsibility of all to ensure that today's children and their descendants enjoy the material benefits of the atomic age, but also that their inherited constitution is sufficiently unimpaired for them to do so.

Physician's Handbook. By Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D., and Charles D. Armstrong, M.D. Ed. 10. Pp. 500. Price, $3.00. Los Altos, Calif., Lange Medical Publications, 1958.

The purpose of this Handbook is to provide the student and the practicing physician with a ready reference of practical value in his daily hospital program and medical practice. Since its first appearance in 1941, it has been revised every two years to include selected items of medical information as they became established

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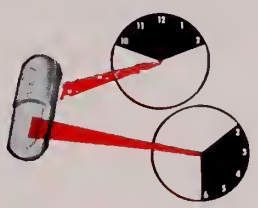
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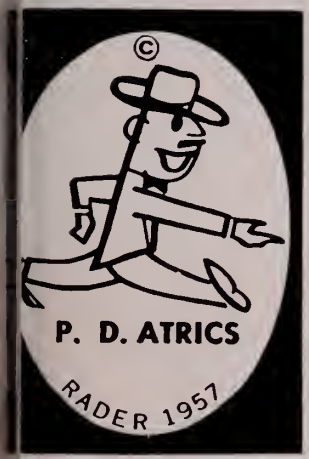
as useful among physicians and medical educators. It has steadily grown in popularity and is now being distributed to all the free countries of the world. As with previous editions, this tenth edition is purposely somewhat loosely organized as a series of chapters containing brief discussions of those diagnostic and therapeutic procedures which the authors believe are of greatest daily interest to the student and the practitioner. In all chapters a basic medical background is assumed on the part of the reader. The Handbook, therefore, is of greatest interest to students of medicine, nursing, and the technologic aspects of the various medical specialties after the fundamental vocabulary and principles have been mastered.

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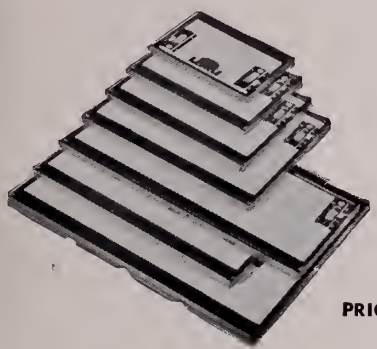
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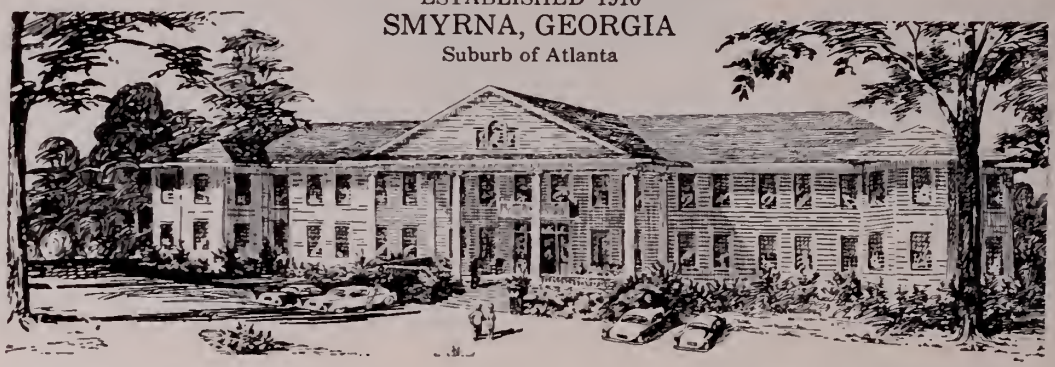
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al. & Otol., Soc. of	Edson J. Andrews, Tallahassee	Joseph W. Taylor Jr., Tampa	Miami Beach, May 2-6, '59
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A. Clinical Session			Minneapolis, Dec. 2-5, '58
rn Medical Association	W. Kelly West, Oklahoma City	Mr. V. O. Foster, Birmingham	
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astern Surgical Congress	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta	Miami Beach, Mar. 9-12, '59
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	63
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	2nd Tues.	31
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	1st Tues.	60
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	2nd Tues.	221
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	3rd Wed.	13
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	925
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	27
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	350
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	118
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	237
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	14
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	33
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	80
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	7
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	33
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	36
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	15
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	9
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	230
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Herman Baxt, W. Palm Beach	4th Mon.	171
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	293
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	129
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	13
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Reuben J. Plant Jr., St. Augustine	3rd Tues.	22
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	84
Seminole	Daniel H. Mathers, Sanford	Vann Parker, Sanford	2nd Tues.	17
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	6
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	94
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	30
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6
				3,491
			Direct	4
			Total	3.495

* *Supervise and aid until organized separately.*



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*Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. *23*:41 (Jan.) 1958.

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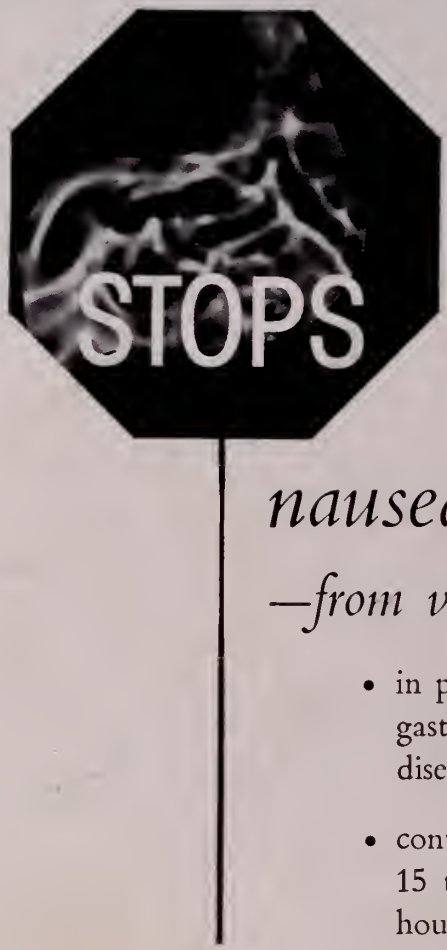
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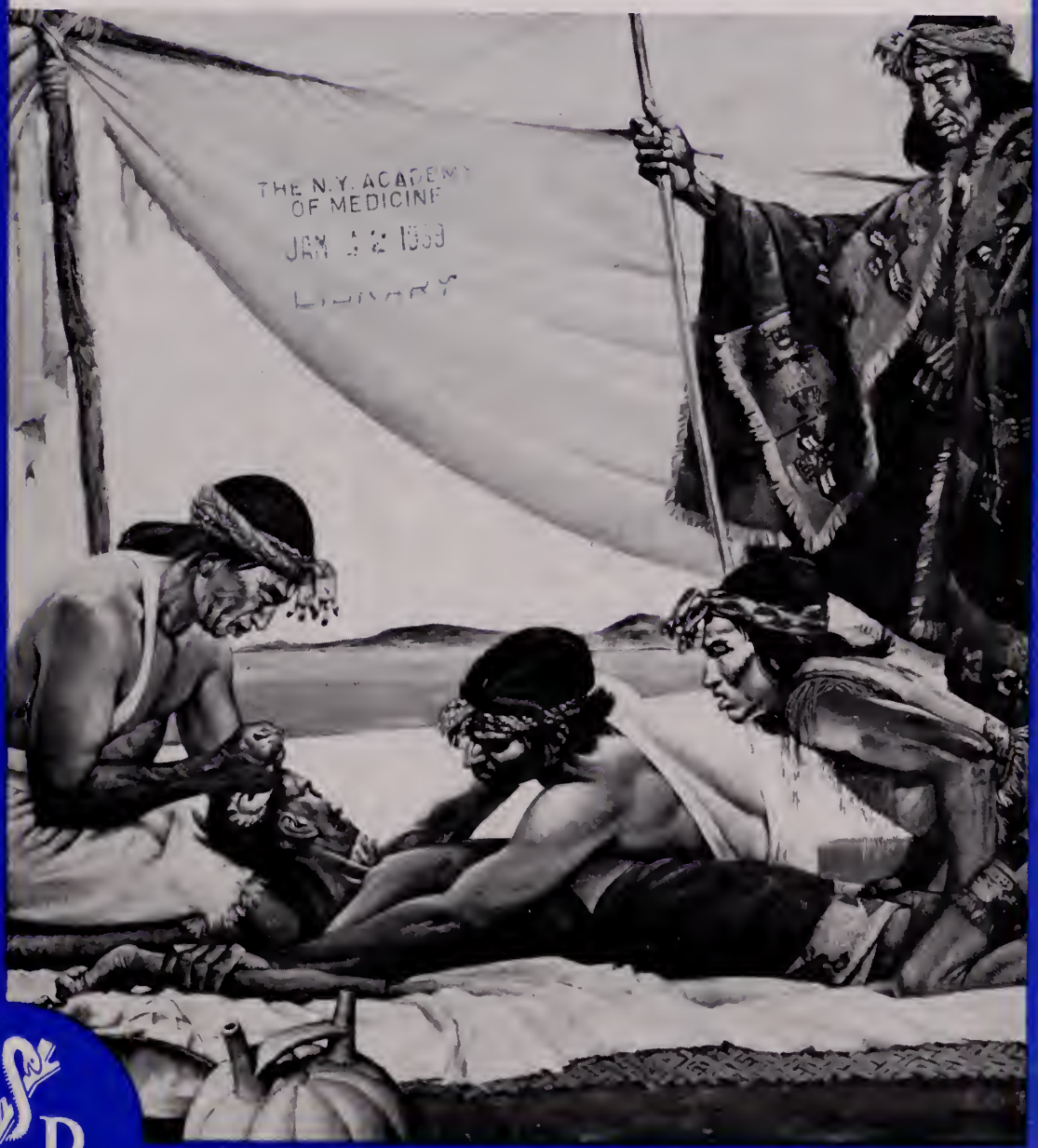
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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLV JANUARY, 1959 No. 7



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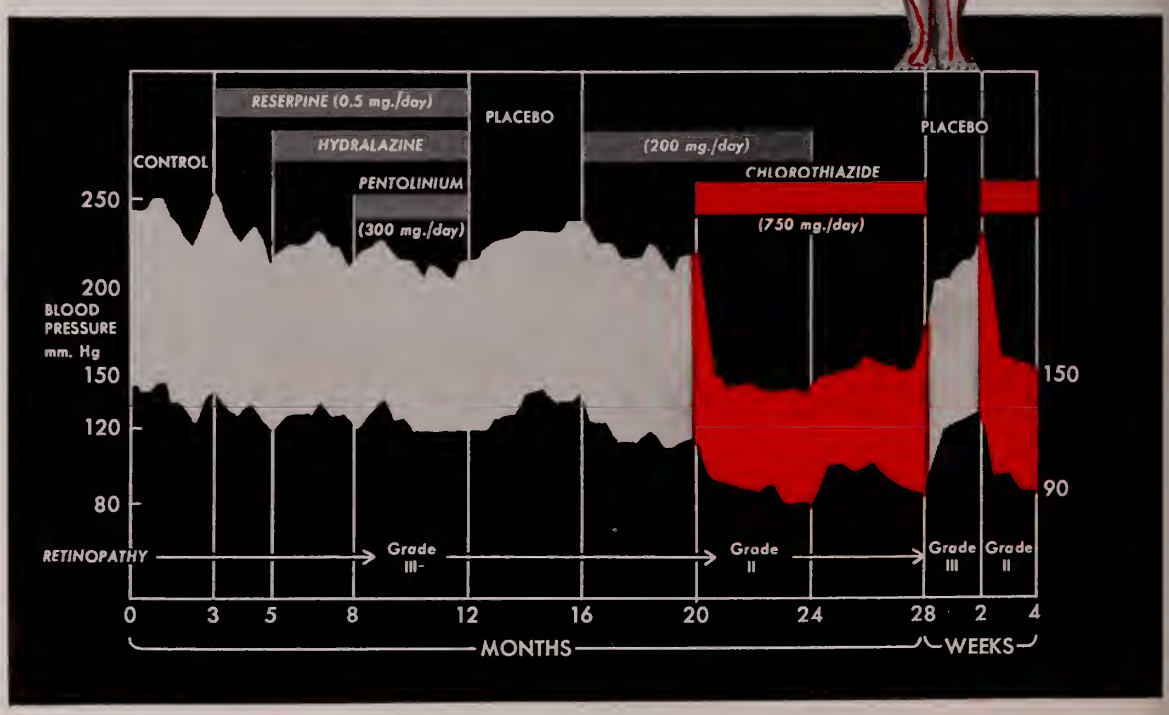
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."





In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September 1957.

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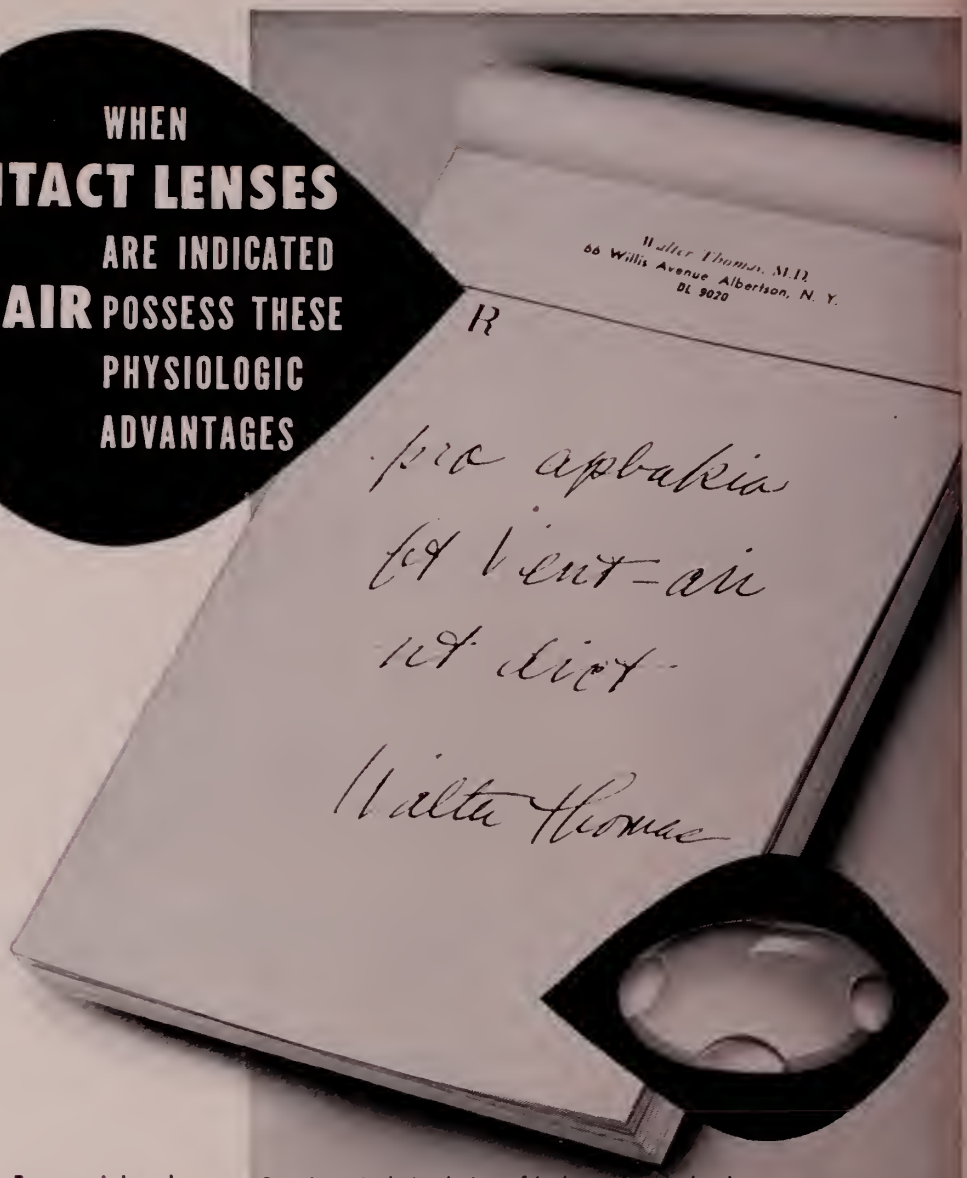
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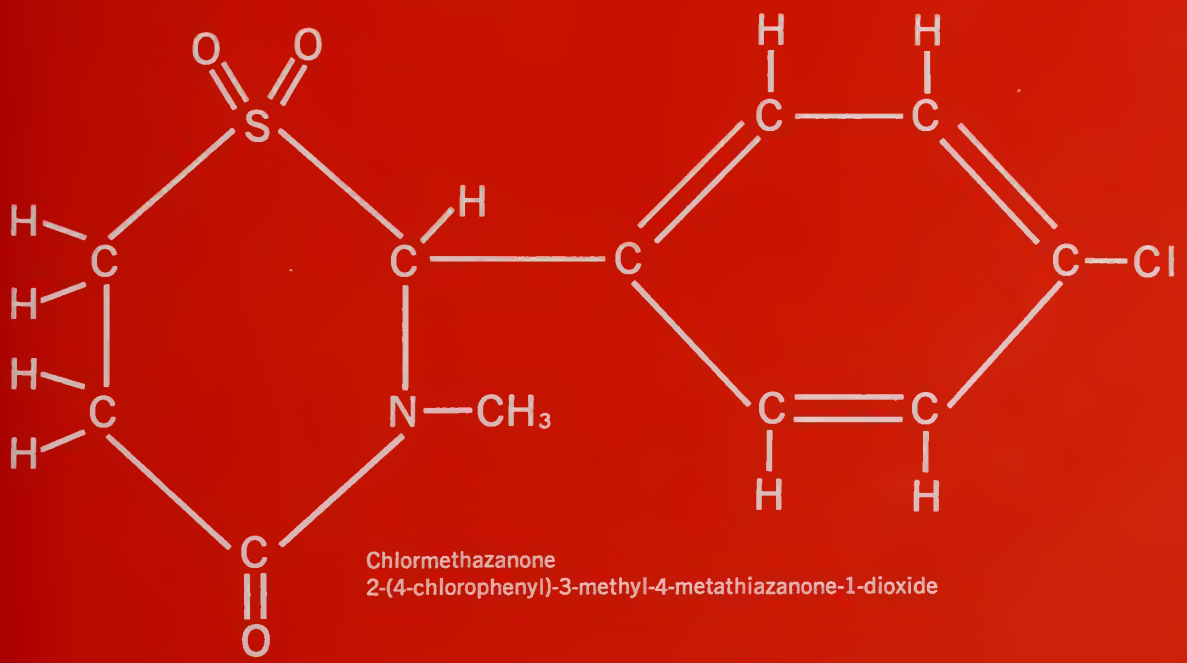
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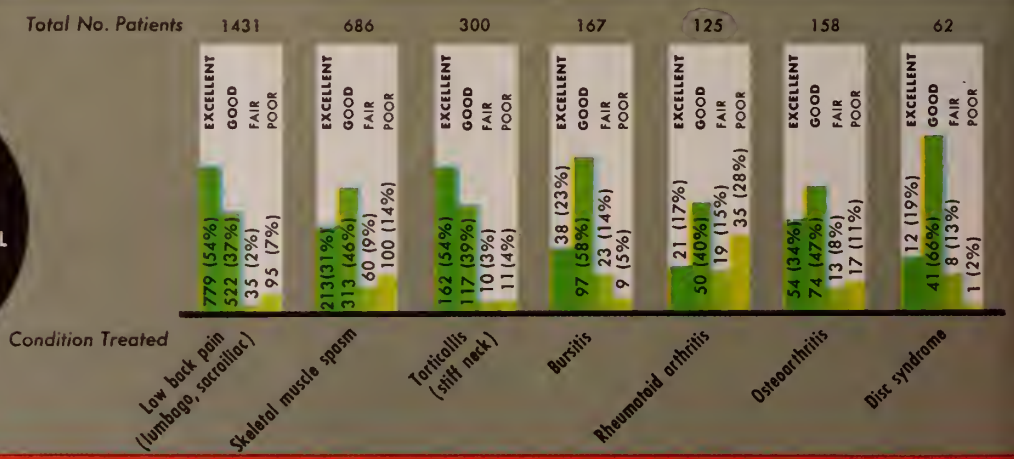
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[< L. tranquillus, quiet; L. laxare,
loosen, as the muscles]

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2929 Patients

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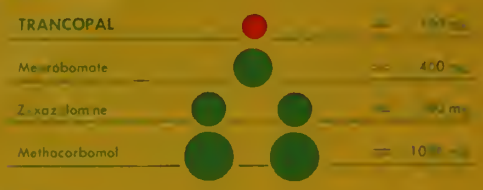
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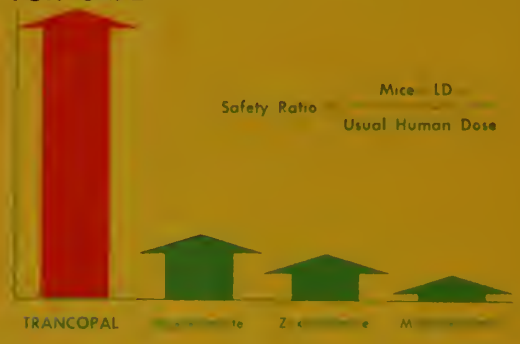
Single Dose



Daily Dose
Same as above t.i.d.

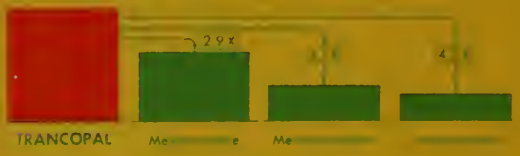
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FOR CLINICAL EFFECTIVENESS



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INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations."

(Lichtman)

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."

Trancopal ". . . was effective in relieving the symptoms of anxiety . . . [with a] profile of pharmacologic actions similar to meprobamate . . ."

(Mullin and Epifano)

"We have just started using it [Trancopal] for relaxing spastic musculature and are very much encouraged."

(Baker)

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the first true "TRANQUILAXANT"

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• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperat Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exp Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Ther 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Mul W. G., and Epifano, Leonard: To be published. • Surrey, A. R.; Webb, W. G., and Gesler, R. J. Am. Chem. Soc. 80:3469, July 5, 1958.

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"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

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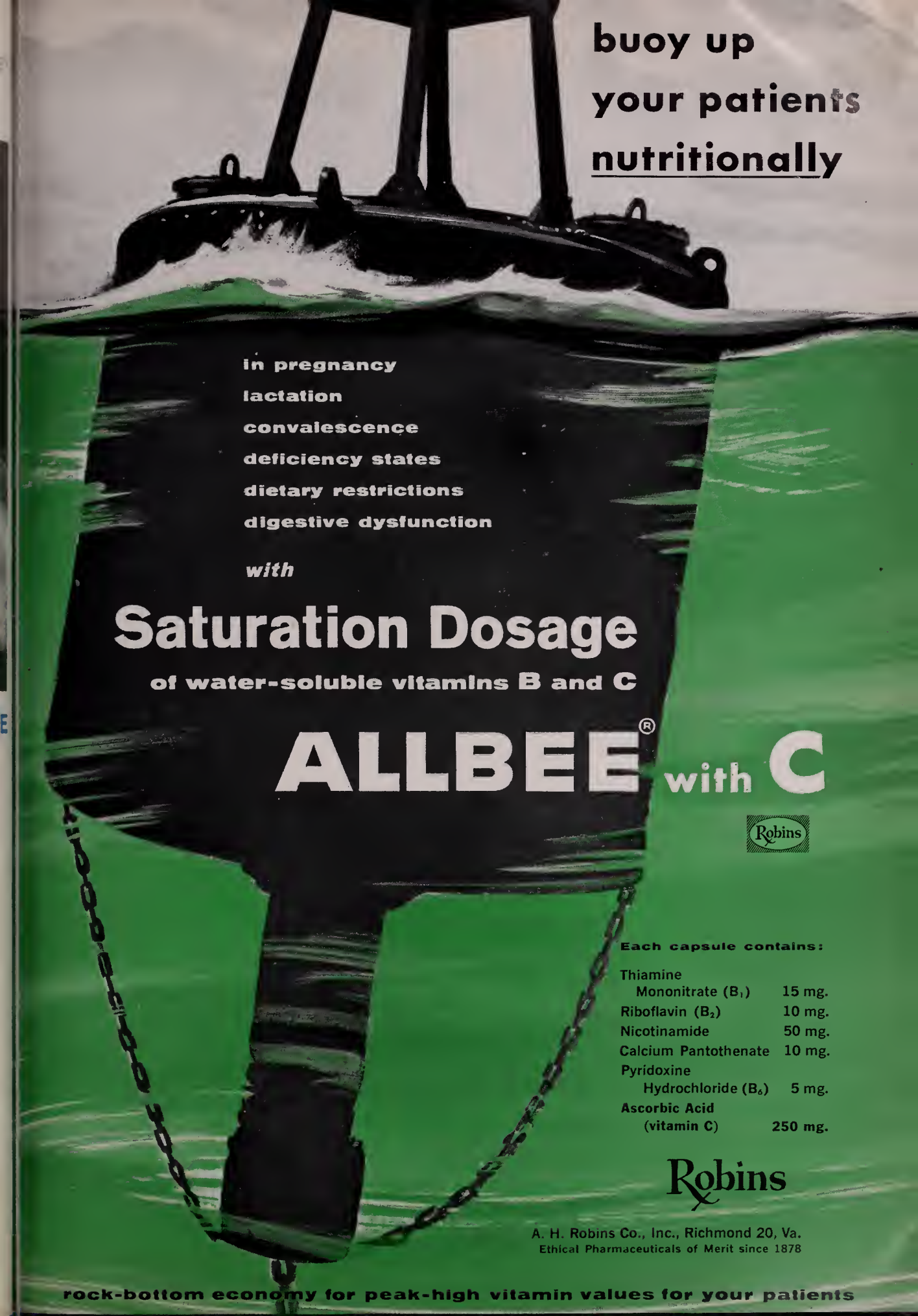
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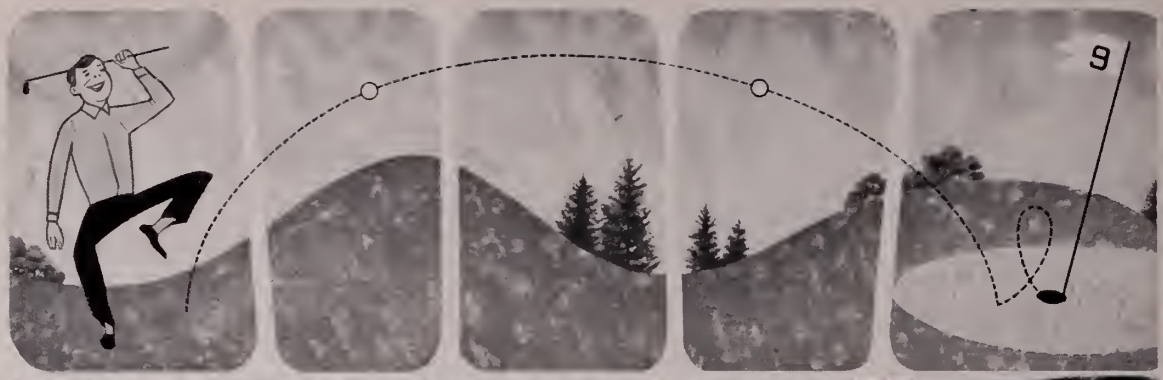
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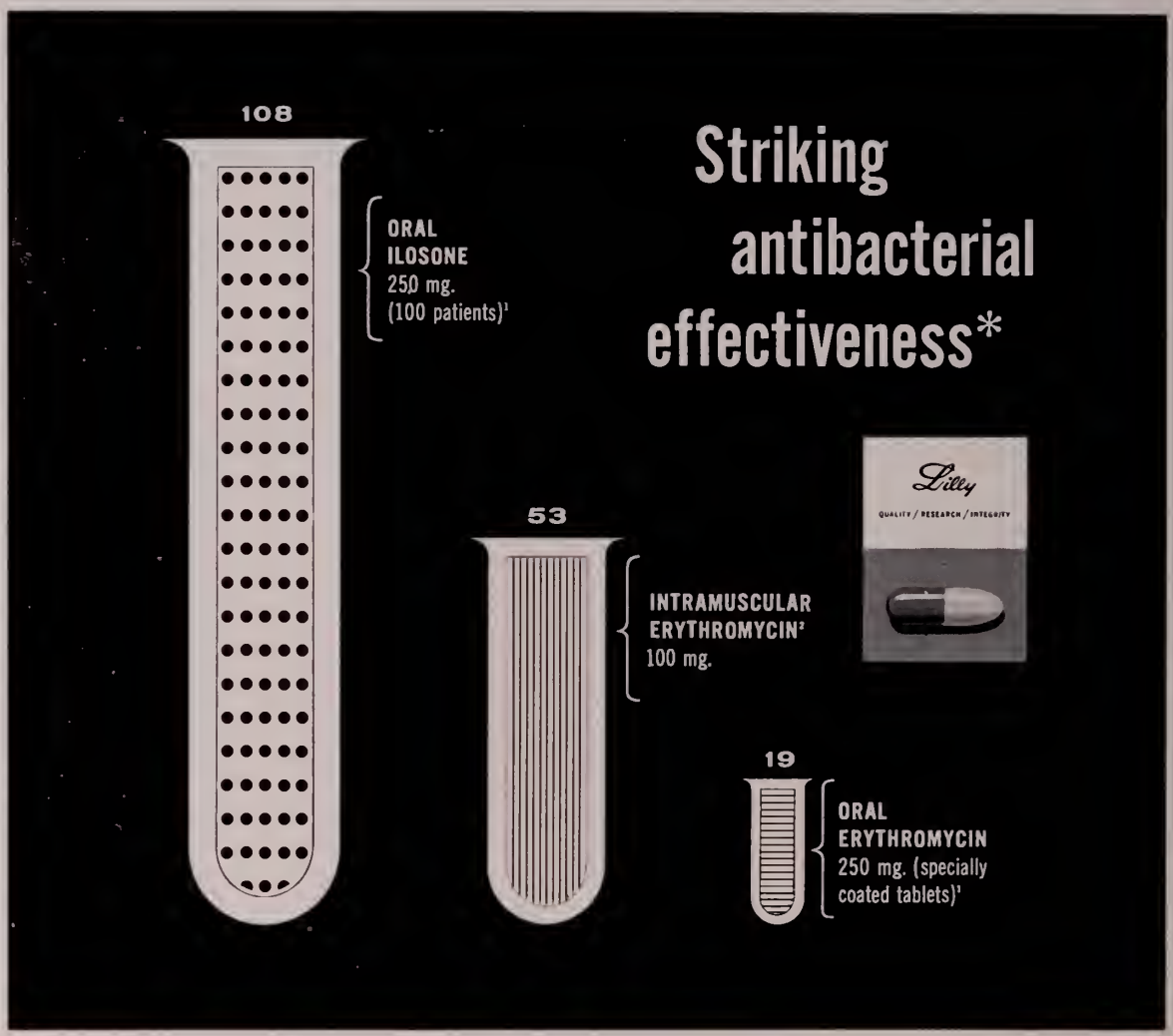
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1. Griffith, R. S., *et al.*: Antibiotic Med. & Clin. Therapy, *5*:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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The Role of the General Physician In the Changing Picture of Tuberculosis

David T. Smith, M.D.
Durham, N. C.

The rapid decrease in the death rate from tuberculosis in the past decade coincided with the introduction of streptomycin, para-aminosalicylic acid and isoniazid. The new drugs alone, however, do not deserve all of the credit for the decrease in deaths. The drugs have been successfully superimposed upon improved case finding, better diagnostic clinics, more and better sanitoriums and improvements in surgical technics.

A Critical Evaluation of the Declining Death Rate

The precipitous decrease in death rate has been interpreted by the newspapers and magazines, and probably by a majority of the public, as an indication that the tuberculosis problem has been solved and all we need to do is to fold our hands, stand aside and let the death rate float on down to zero. The closing of some sanitorium beds in various parts of the country is considered proof that tuberculosis is licked. The fallacy in the latter conclusion is obvious, when one realizes that the new drugs have reduced by 50 per cent the average period of hospitalization which is the equivalent of suddenly doubling the number of available sanitorium beds. An examination of the data reveals that there has been only a moderate decrease in the number of new cases during the time of the dramatic decrease in the number of deaths.

The decrease in deaths can be attributed primarily to improved medical and surgical therapy and not to an alteration in the nature of the disease or in the virulence of the tubercle bacillus. When tubercle bacilli are isolated from the patients, who now usually recover with the newer therapy, and are injected into experimental animals, the animals die quite as readily as they did following the injection of tubercle bacilli isolated from patients who formerly died of the disease.

It is difficult for the public to realize that a rapid fall in the death rate will not automatically result in a corresponding rapid disappearance of the disease. When there was a rapid reduction in the death rate from diphtheria and typhoid fever, there was indeed a rapid decrease in the incidence of the disease, almost to the point of elimination. Why then does this not occur with tuberculosis? The answer is obvious to the physician. The incubation period, between the invasion of the body and the development of the disease, is measured in days with diphtheria and typhoid fever, but must be measured in years in tuberculosis. In a study by Zeidberg, Dillon and Gass [1] in a rural county in Tennessee a single period of exposure and infection in infants was followed by a step-ladder-like manifestation of the disease over the next 20 years. Theoretically, it is possible for an infection at the age of eight years to produce clinical disease at the age of 80 years.

Profound changes are occurring in the age and sex distribution of tuberculosis and corresponding changes in the type of clinical problems confronting the physician.

Tuberculosis in Infancy

It has been known for generations that children under two years of age have an increased susceptibility to clinical disease and death as compared to children between five and 10 years of age. In 1900 in the United States the death rate in children under two was over 300 per 100,000 and between five and 10 only 30 per 100,000 (fig. 1). By 1954 the infant death rate in white children was only two per 100,000 and that in children from five to 10 was almost zero (fig. 2). This dramatic change is not due to the

Chairman of the Department of Bacteriology, Duke University School of Medicine, Durham, N. C.

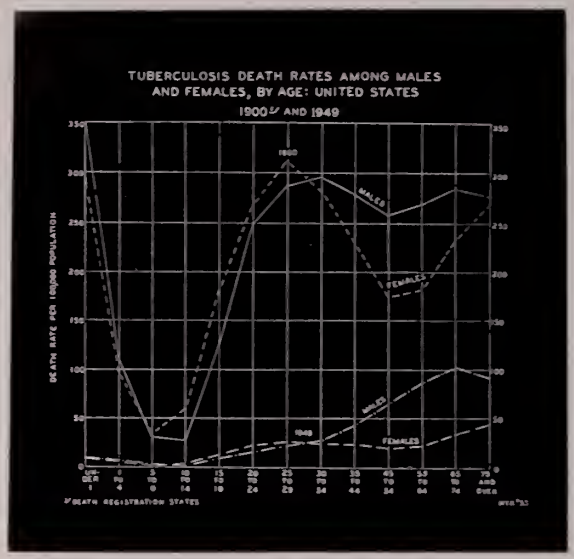


Fig. 1.—Death rate from tuberculosis in males and females in 1900 and in 1949. From Statistical Division of the National Tuberculosis Association.

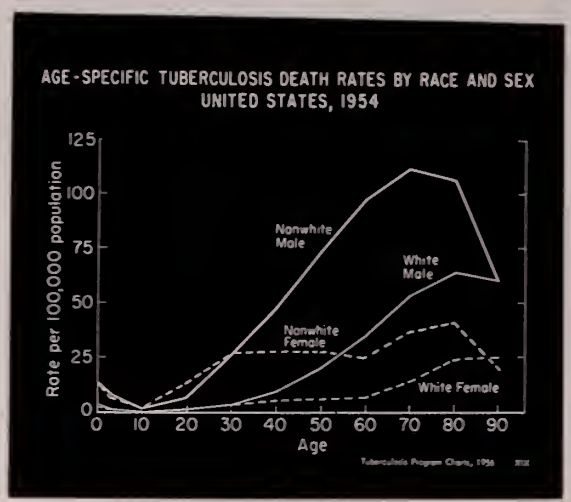


Fig. 2.—Death rate in males and females for white and nonwhite population for year 1954. From Tuberculosis Chart Series 1956. U. S. Department of Health, Education, and Welfare.

sudden acquisition of resistance by infants but to the absence of infection. Fifty years of hard work in case finding, education, detection and isolation of open spreaders of the disease supplemented by improvement in housing, diets and the general standard of living have resulted in the protection of infants from primary infection with the tubercle bacillus.[2]

Tuberculosis at Puberty

Physicians know that a second period of increased susceptibility to tuberculosis begins at puberty and extends into young adult life. This change is obviously linked in some unknown manner with puberty since the sharp rise begins in girls at the age of 10 years and in boys at the age of 12 years. The rate climbs rapidly and in 1900 reached a peak of 275 for males and 325 for females of the age of 25 years. This sharp rise at puberty disappeared in the white population by 1950, although it remains in a less dramatic form in the nonwhite population, which includes Negroes, Mexicans and Indians. The new drugs are responsible for only a minor part of this reduction. Indeed, in certain midwestern states, such as Minnesota, the puberty peak had disappeared by 1940, which was prior to the introduction of the new drugs.[2] The rate of the reduction in the puberty peak corresponds almost precisely with the efficiency of the control program in each state. This improvement also resulted from prevention of infection and not from a change in the virulence of the tubercle bacillus or an increase in the resistance of the individual.

Tuberculosis in Middle Age

In 1900 there were fewer deaths among those in middle age than among young adults. Between the ages of 25 and 45 the death rate in males decreased from 275 to 225 and that in females from 325 to 175. The exact cause of this reduction is not known. We do know that tuberculin tests made in the early decades of the twentieth century showed more than 90 per cent of adults of the age of 25 years were already infected with the tubercle bacillus. It may be assumed that the previous rapid rise in deaths between 10 and 25 years was a combination of stresses and strains, endocrine adjustments, and rapidly increasing infections. The more susceptible individuals would have already succumbed to the disease by the age of 25 years. The fall in death rate from 25 to 45 coincides with a reduction in these stresses and strains and a reduction in new infections.

By 1954 a new pattern had emerged in the middle age population (fig. 2). The deaths in white females increased only slightly from four at 30 to six at 60. In contrast, deaths in males increased from four at 30 to 40 at 60. There is suggestive but not conclusive evidence that the increase in deaths in males is a result of more new infections acquired by more human contacts in laboring groups or in business activities (fig. 3).

Tuberculosis in Old Age

Medical schools have been teaching for generations that old people were less susceptible to

tuberculosis than adolescents and young adults. European statistics, and particularly those from Sweden, support this conclusion. In 1900 in Sweden the lowest death rate for all adults was age 70. We have rather convincing evidence now that there is a third period of increased susceptibility in old age which begins in the white female at about age 60. In 1954 the white female death rate was six at 60 and 25 at 80 years. The onset of the age of increased susceptibility for the white male is less well defined, but may begin as early as 45, and it reaches a maximum of 60 at 80 years. Two factors are operating in the case of the white male: the steadily increasing rate of infection from business contacts is superimposed upon the effect of an increasing state of susceptibility. How then can we explain the apparent increase in resistance shown by the European statistics? These statistics were collected before there were effective control methods, and the entire population from infancy to middle age was constantly and universally exposed to massive infection. Perhaps all the really susceptible individuals died off before reaching old age.

Even in 1900 in this country there was some evidence of increased susceptibility in old age as compared to middle age. Males had a death rate of 260 at age 45 and 280 at age 65. Females showed a greater increase from 175 at age 45 to 260 at age 75.

New Case Rate Versus Death Rate

The steady decline in the death rate for the three decades immediately before the introduction of the new drugs can fairly be attributed to better case finding, better diagnostic clinics, better sanitorium care and a general rise in the standard of living. More important than the reduction in death rate was the reduction in the amount of new infections in infants, in school children and even in college students. While exact figures are available for only small areas of the country, these that are available suggest that tuberculous infection, as measured by a positive tuberculin test, in school children has declined from 20 to 30 per cent to 3 to 6 per cent and in college students from 30 to 60 per cent to 6 to 15 per cent. With the reduction in infection the excessive death rate in infants and young adults had almost disappeared even before the introduction of the new drugs. The new drugs, however, have accelerated the decline in death rate of persons of all ages and particularly those in the middle and old age

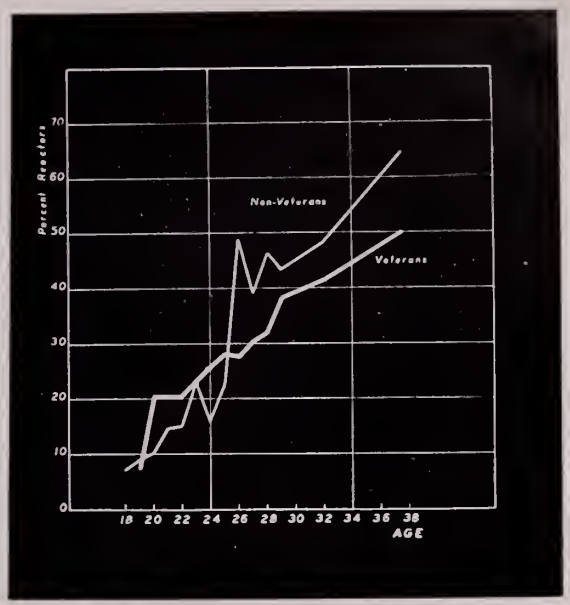


Fig. 3.—Per cent of tuberculin reactors by age for veteran and nonveteran students of the University of Minnesota. From Myers, J. A.; Boynton, R. E.; Kernan, P.; Cowan, D., and Jablon, S.: Sensitivity to Tuberculin Among Students at the University of Minnesota, Amer. Rev. Tuberc. and Pul. Dis. 75:442-459 (March) 1957.

groups who now produce the major proportion of the new cases.

The death rate is no longer an accurate guide to the progress being made in the control of tuberculosis. The death rate could reach zero without affecting the number of new cases or the cost of treatment. To effect a reduction in the case rate the open spreader of the disease must be discovered before he or she has infected others. To cure all of the spreaders, but only after they have planted the seed for a new crop of cases, is to perpetuate the vicious and never-ending cycle of infection and reinfection.

Our guide for the future must be the number of new cases appearing each year. In 1954 the new cases were lowest in the five to 10 year group, being only 10 per 100,000. After 10 years there was a sharp rise to 50 at the age of 18 years and a progressive increase to 85 at 75 years of age.

Changes in Clinical Patterns

The changes in case rates and death rates by age and sex here discussed have brought about profound changes in clinical patterns of disease. Every physician must recognize and be prepared to deal with these changes as they affect his practice.

Primary tuberculosis, with its complications such as adenitis, bone and joint lesions, meningitis and miliary tuberculosis, was formerly the re-

sponsibility of the pediatrician since most of these infections occurred in childhood. This is no longer true. Primary infections are being postponed and now appear in adults of any age even up to 60 or 80 years.[3]

It is my impression that primary infections in adults produce less massive lymph node reactions, much less meningitic and miliary tuberculosis and rarely, if ever, lesions of the bones and joints. They may produce a generalized disease which slowly invades many organs of the body. This generalized disease is less rapid and fulminating than the corresponding type of infection in children but no less fatal if it is not diagnosed and treated. Old people frequently have surprisingly low grade febrile reactions even in the presence of a progressive tuberculous infection.

Most physicians dealing with adult patients expect them to have the old type of reinfection tuberculosis which is confined to the lungs and is characterized by the presence of parenchymal infiltration, cavities, and fibrosis. This type of tuberculosis is not associated with appreciable enlargement of the lymph nodes in the chest or elsewhere. The spleen is not enlarged, and lesions in organs other than the lungs are extremely rare. Consequently, when a patient presents himself to the physician with subacute or chronic fever, loss of weight, increase in sedimentation rate and multiple organ symptomatology, the physician immediately thinks of one of the more complex diseases. When the complete examination reveals enlarged lymph nodes by palpation or by x-ray and possibly an enlarged spleen, he must consider the possibility of (1) lymphomas, (2) neoplasms, (3) collagen diseases, (4) fungus diseases and perhaps tularemia or brucellosis or some unusual type of reaction to ordinary bacteria or sensitivity to a drug. Primary tuberculosis, however, should always be considered in the differential diagnosis of patients presenting the findings listed. It is our practice to search for tuberculosis first because even a generalized tuberculosis, with modern therapy, has a better prognosis than lymphomas, neoplasms or collagen diseases.

The Tuberculin Test

The tuberculin test has become an essential part of the study of every complicated medical case. In the early decades of this century the tuberculin test was rarely used in the study of medical cases in adults because in almost all adults the reaction was positive and had been positive since childhood. The situation is quite different at the present time. In many areas 85 to 90 per cent of young adults give a negative response to tests and in from 40 to 50 per cent the results are negative even after 50 years of age. A tuberculin test with negative results is of great value in eliminating the possibility of tuberculosis in a difficult diagnostic problem, but a "negative" test used in this positive manner must be carefully defined. A known potent tuberculin must be used, the solution must be fresh, the injection must be given in the most superficial layers of the skin, and the dose must be adequate. An adequate dose can be defined as 0.1 cc. of a 1:100 dilution of Old Tuberculin (1 mg.) or 0.1 cc. of second strength PPD (0.005 mg.). Even under these conditions a critically ill patient may give a negative response to the test and yet have tuberculosis. This test, however, as here defined is probably accurate in eliminating the possibility of tuberculosis up to 98 or 99 per cent of cases.

A positive reaction to the tuberculin test does not establish the diagnosis of tuberculosis. It is true that a strong reaction to a small dose of tuberculin (1:1,000 O.T. or 0.0001 mg. PPD) selects out healthy individuals in whom tuberculosis is more likely to develop in the next three or four years in a ratio of three to four times as frequently as in those who react only to the stronger doses. This detection of the more susceptible individual was discovered independently by Dr. Carroll Palmer and his associates in the Public Health Service[4] and by the Committee of the British Research Council.[5]

In survey work in school children and even surveys of adults, it is not practical to test with multiple doses, but much can be learned with the single dose (0.0001 mg. PPD or 5 T.U.). In diagnostic work, however, in clinics and hospitals at least two and preferably three dilutions of tuberculin should be used. An initial test dose of 1:10,000 of O.T. or first strength PPD should be employed. If there is no reaction in 24 hours, a stronger dose, such as 1:1,000 O.T. or 5 T.U. PPD (0.0001 mg.) can be given. Those patients giving a negative response to the intermediate dose should receive the final dose of 1:100 O.T. or second strength PPD before concluding that they have a negative reaction to tuberculin. The final reading of the tuberculin test should be at 48 or 72 hours after the injection.

The patch test, as now manufactured, is reliable in infants and young children at a level

equivalent to 1:1,000 O.T. or 5 T.U. PPD. In older children the patch test gives 10 to 20 per cent false negative reactions. The original patch test[6] gave results comparable to the 1:1,000 O.T. in children and young adults. A new patch test equal to or superior to the original one is certainly needed. With such a patch test it would be easy and economical to include a tuberculin test as a part of the routine study of every ambulatory patient who comes to the office of the family physician. If the test were positive, sputum studies for tubercle bacilli and x-rays of the chest should be made. These positive tuberculin reactors should receive regular routine follow-ups each year for the remainder of their lives so that if the infection ever becomes active, it can be detected in a stage when it can be cured readily and before the infection has been transmitted to others.

Summary and Conclusions

Great progress had been made in the control of tuberculosis before the introduction of the new chemotherapeutic drugs. Case finding, clinics, sanitoriums and general improvement in the standard of living had reduced the infant mortality from over 300 per 100,000 in 1900 to about two per 100,000 in 1954. The death rate in young adults of 25 was reduced from around 300 per 100,000 in 1900 to four in 1954. This reduction was accomplished primarily by preventing infection. Periodic testing with tuberculin has shown a progressive decrease in the number of infants, children, and even adults who react to the tests.

The new drugs have accelerated the decrease in death rate, particularly in the middle-aged and elderly patients, but they have had little effect in preventing the appearance of new cases. The new drugs can supplement but in no sense substitute for the tested and proved methods of controlling tuberculosis.

In 1900 tuberculosis was most often fatal in infants, young adults and women. By 1954 the high incidence in infants and in young adults had been eliminated. The reduction of mortality in women has been phenomenal. Most of the deaths from tuberculosis are now in middleaged and elderly men and in women over 60 years of age.

These epidemiologic changes in tuberculosis present new problems to the practicing physician. Primary tuberculous infection is becoming rare in children of pediatric age as infection is postponed from infancy and childhood to adult age. Primary infections, with their varied and complex symptomatology, now occur with progressively greater frequency as problems in differential diagnosis in adults. These patients not infrequently present clinical pictures which resemble those shown by patients with lymphomas, neoplastic diseases, or collagen diseases.

The tuberculin test is becoming a routine diagnostic test for every practitioner, analogous to a routine urine test. The negative result of a urine test last year does not guarantee the patient that diabetes or nephritis has not developed in the past 12 months; so the test is repeated. The tuberculin test, although giving a negative result last year, must be repeated, and if the response is positive, we know the infection is less than 12 months old and readily curable if active.

Tuberculosis is decreasing the sanitorium population but increasing in the general hospital where the patients are being admitted under other diagnosis. The disease is moving from the province of the old tuberculosis specialist into the hands of the general practitioner. He will meet this challenge and will become the leader in the final drive not to control but to eliminate tuberculosis.

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Reversal of Intractable Cardiac Edema With Prednisone (Meticorten)

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The number of cases of refractory cardiac edema has been on the increase. It is trite but true that with the increase in longevity more people live long enough to have cardiac disease: and, with improved management of congestive failure, many more of them survive beyond the former span of their disease — long enough for it to become refractory.

This paper was originally intended to be a clinical report on the reversal of intractable cardiac edema by the use of prednisone (Meticorten). Eight successful cases were the basis of this report. Since, however, this project was started three years ago, a number of new and potent diuretics have appeared, particularly chlorothiazide. It seemed that prednisone had been superseded and would remain only of academic or historical interest. I do not think that this is true; there is good reason to believe that the usefulness of prednisone in some resistant cases of intractable failure is still not duplicated by any other presently available agent.

Without going into a discussion of the mechanism and causes of intractable failure nor of the accepted and standard methods of treatment, I should like to mention some of the more recently described attempts to break through the refractory state by specially devised technics, such as the induction of a chloride acidosis, that is, a hyperchloremic acidosis, by the combined use of ammonium chloride and Diamox; the use of large doses of aminophylline intravenously to increase glomerular filtration; the loading with osmotic diuretics, such as urea orally or mannitol intravenously; the use of 5 per cent salt solution combined with water restriction; the use of alcohol to inhibit antidiuretic hormone secretion; and finally, and most recently, the combined use of chlorothiazide and mercury.[1-3]

There comes a time, however, when all these measures fail. Attempts to force mercurials in the face of failing responsiveness may only aggravate the situation and induce azotemia and dilutional hyponatremia.[4] Water is paradoxically retained in excess of sodium.[5] The homeostatic mechanisms for maintaining a constant osmotic pressure of the body fluids, mediated by the neurohypophysis and the aldosterone-secreting adrenals, no longer function properly. The body cells are sick; their viability is impaired, and their membrane permeability is changed adversely. They lose potassium; the *intra*cellular osmotic pressure falls; they lose water, and sodium enters the cells to replace the lost potassium. With salt moving into the cells and water moving out of them, the end result is that the *extra*cellular fluid space becomes salt-depleted and waterlogged and therefore no longer responsive to saluretic diuretics. The edema is now intractable.

Use of Steroids

It is at this point that my experience with the use of steroids in edema states began. An accidental observation about four years ago had to do with the successful use of cortisone to reverse a severe postoperative "low salt syndrome" when prior to its use, huge amounts of 5 per cent salt solution intravenously were ineffective. It seemed that cortisone effected a salutary change in cellular membrane permeability which allowed a reverse shift of electrolytes from the "body sodium stores" and from the intracellular fluid space out into the extracellular fluid space.[6] That cortisone and ACTH could do this had been demonstrated experimentally by Levitt and Bader and by others several years earlier.[7,8]

About this time, in 1954, I believe premised on the same idea, Schemm and Camara[9,10] reported the successful use of ACTH to reverse hopeless and refractory cardiac edema in 17 out of 21 cases. This was completely contrary to the then held views concerning the dangerous salt and water–retaining effects of corticotropin. It was considered by many to be radical, hazardous, illogical and even unbelievable. Be that as it may, in January 1955 I tried to duplicate their pro-

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cedure in precise detail on a 72 year old patient in hopeless and intractable failure. There was a good initial response, but it did not hold. The edema recurred, and he failed to respond to all further therapeutic efforts. I considered this attempt a failure and did not try ACTH again.

When prednisone first became available and was reported to be relatively free of the salt and water–retaining properties of the earlier steroids,[11,12] it seemed to be ideally suited for the therapeutic trial I had in mind. In the face of many warnings in the literature against the use of steroids in heart failure, I undertook this therapeutic experiment with a great deal of trepidation. Although prednisone had been used in many noncardiac conditions that in some instances had coincidental edema of varying etiology, it had not been used specifically for cardiac edema as such. My rationale was based on the idea that if prednisone, like cortisone in Levitt and Bader's experimental study, would effect an intercompartmental redistribution of electrolytes, with a back shift of sodium from the body's electrolyte pool of the so-called "stores of exchangeable sodium"[13] out into the extracellular fluid compartment, then it would make salt available or accessible to the action of mercurials; mercurial fastness would thus be reversed.

Analysis of Series

I have had 10 cases of intractable cardiac edema that I considered desperate enough to warrant the use of drastic measures. The patients were all private patients, treated mainly as outpatients, hospitalized only for acute episodes, usually not long enough to carry out detailed metabolic studies. I can submit, therefore, only *clinical* data, observations and impressions: The 10 patients ranged in age from 60 to 85 years. There were seven men and three women. All had arteriosclerotic heart disease; six had hypertension, and five of these had had myocardial infarctions previously; two had aortic regurgitation; one had pericardial calcification and constriction; one had diabetic glomerulosclerosis with the nephrotic syndrome; three had associated bronchopulmonary disease, and one of these had a known though quiescent duodenal ulcer.

All of them but two were in relatively normal electrolyte balance. The two who were not had a moderate hyponatremia of about 128 milliequivalents of sodium per liter. All of them had been under treatment for congestive heart failure for two or more years, had exhausted all standard therapeutic measures and had become unresponsive to mercurials, to chlorothiazide, and to all other types of therapy, including induced hyperchloremic acidosis and aminophylline. Their condition was apparently hopeless.

The general contraindications to steroids were considered in each case as regards the hypertension, the diabetes in the patient with the nephrotic syndrome and the known duodenal ulcer in the patient mentioned. These were considered to be warranted calculated risks and were guarded aaginst accordingly with appropriate countermeasures.

The prednisone was started in doses of 2.5 mg. a day. It was cautiously increased to between 15 and 20 mg. a day for four or five days and was then gradually decreased over a varying time interval, depending on each patient's response to the mercurial given after the priming with prednisone. The maintenance dose, after satisfactory responsiveness was re-established, varied from as low as 2.5 to 5 mg. a day in one patient to as high as 10 mg. a day in two. The average was 5 mg. a day. Others have reported since then that the smaller doses are more effective,[14,15] that when the larger doses are used, "sodium-retaining effects come into play to dominate the sodium excretory effects of the smaller doses." There appears to be a critical dose level that varies with each patient's responsiveness, at which a given amount of prednisone will have either a predominantly sodium-retaining or sodium-excreting and diuretic effect. One has to find that level empirically for each patient.

No other change in standard therapy for congestive failure was instituted. Water and fluids were neither restricted nor forced, except that in the two cases in which hyponatremia was present, moderate restriction to 1 to 1.5 liters per day was recommended. Salt restriction was urged to a maximum of 1 Gm. per day. Eight ounces of orange juice daily was recommended, and potassium supplements were added in those cases in which reduced serum potassium levels were present. Ammonium chloride was given for one day before, one day during and one day after the mercurials, when these were given by injection.

The response in the eight successful cases was gratifying. In four there was at first a moderate gain in weight amounting to 3 to 4 pounds during the first four or five days; then, on about the fifth day there was a moderate diuresis

amounting to 2 to 3 pounds over and above the weight gained. This was on prednisone alone. Then, when a mercurial was given, after priming with prednisone as described, a brisk diuresis took place resulting in a decrease in weight varying from 8 to 18 pounds. More recently the same effect was obtained with chlorothiazide. With the onset of diuresis the dosage of prednisone was gradually reduced to a maintenance level. Cardiac compensation improved with the diuresis. In the two cases in which hyponatremia was present, there was an increase in the serum sodium levels. The diuresis was characterized by a greater output of water than of chloride.

The most gratifying feature in the eight successful cases was the subsequent return of responsiveness to diuretics—not only to mercurials by injection in much smaller dosage than previously, but also to Diamox, to chlorothiazide, and even to Neohydrin orally. These were given subsequently as needed. Responsiveness to them continued as long as prednisone was given in small maintenance doses, except in those in whom intercurrent complicating disease developed. In several cases it was possible to maintain a satisfactory output of urine for long periods with as little as three tablets of Neohydrin a day supplemented with two tablets of Diamox a week; more recently good maintenance was achieved with 0.5 to 1 Gm. of chlorothiazide daily supplemented with an occasional injection of 0.5 to 1 cc. of Mercuhydrin —all this so long as small maintenance doses of prednisone were continued. Diamox seemed to be unusually effective in the cases with bronchopulmonary disease and in the one case with constrictive pericarditis.

Of the 10 cases, the first one, treated with ACTH as described, was a failure. In another one, the patient died from a cerebrovascular accident on the fourth day of treatment with prednisone before a diuresis was obtained. In eight patients a good remission was achieved. Of the eight, five remained in good compensation for a period ranging from nine to 28 months. Three patients died. One of these, a man aged 76 (case 6) with pericardial constriction and previous myocardial infarction, had been in excellent compensation for over two years on two tablets of Diamox a week and 2.5 to 5 mg. of prednisone a day until two months ago when he died suddenly from a pulmonary embolus after he had discontinued this program in favor of chlorothiazide, without prednisone. One of the other two died nine months and one 14 months after the initially successful reversal of the intractable failure, the former at the age of 74 from an acute myocardial infarction and the latter at the age of 69 from bronchopneumonia. The intervening period of maintenance had been most satisfactory both as regards relative comfort to the patient and general ease of management.

Report of Cases

Case 4.—A woman, aged 75, had a history of long-standing severe hypertension of 210/120, bronchial asthma and emphysema for many years, and mild hypothyroidism. There was good recovery from an acute myocardial infarction in 1951, but paroxysms of left ventricular failure with pulmonary edema and bouts of recurrent acute coronary insufficiency followed. There was a known silent duodenal ulcer. Also, there was hepatomegaly of 4 to 6 cm. below the right costal margin but no peripheral edema. The patient experienced increasing severity of the left ventricular failure and progression of the right ventricular failure with right pleural effusion and progressively decreasing responsiveness to mercurials. Whereas originally satisfactory fluid balance was maintained with 0.5 to 1 cc. of Mercuhydrin every week or two, now 2 cc. doses at more frequent intervals were no longer effective in securing a diuresis. Serum electrolytes were entirely within normal limits. She was unable to tolerate either ammonium or potassium orally because of the duodenal ulcer and severe gastric symptoms from them. Aminophylline given slowly caused peripheral vasomotor collapse and could not be used again.

Despite the duodenal ulcer, the patient was given prednisone, 5 mg. per day; this was increased to 25 mg. per day by the fifth day. The asthma improved quickly. The responsiveness to Mercuhydrin returned so that once again 1 cc. of Mercuhydrin intramuscularly elicited a good diuresis without side effects. Thereafter the dosage of prednisone was reduced gradually to a maintenance level of 2.5 to 5 mg. per day. Adequate compensation has been maintained since then on 750 mg. of chlorothiazide (Diuril) per day plus 0.75 to 1 cc. of Mercuhydrin once every seven to 14 days. She had two episodes of mild bleeding from the gastrointestinal tract which were adequately compensated for by transfusions of two units of red blood cells. Her blood pressure has been maintained at a level of 170/90. She has now been on this program for two and a half years. Recently, however, there have been some indications of further deterioration and waning responsiveness.

Case 6.—A man, aged 76, who was normotensive, had cardiomegaly and myofibrosis secondary to two previous myocardial infarcts, advanced pericardial constriction and calcification, pronounced hepatomegaly, ascites, right pleural effusion, and peripheral edema 2 to 3 plus. There was hypersensitivity to digitalis, which in ordinary daily maintenance doses of 0.25 mg. of Digoxin caused paroxysmal atrial tachycardia with irregular block. Intolerance of potassium and ammonium chloride orally was manifested by severe gastrointestinal symptoms. Mercurials were effective at first, but became gradually less and less so and, when given, accentuated the tendency to arrhythmia; on one occasion this was associated with transient cerebral ischemia and syncope. Diamox was no longer effective. The serum electrolyte levels were within fairly normal limits, with a minimal reduction of serum sodium to 135 to 136 milliequivalents per liter; serum potassium was 4.2 to 4.6 milliequivalents per liter. The pleural effusion was aspirated on two occasions, and amounted to 800 and 500 cc. of clear fluid each time.

When signs of pleural effusion reappeared while responsiveness to diuretics was failing, prednisone (Meticorten) was started with 2.5 mg. per day and was

cautiously increased to 17.5 mg. per day on the fifth day. Tolerance to Digoxin improved at once, and the arrhythmia reverted to a normal sinus bradycardia of 64. He gained 2 pounds in weight during the first four days. On the fifth day he was given 0.75 cc. of Mercuhydrin. A brisk diuresis followed and continued for a week, during which time he lost 14 pounds, the weight decreasing from 156 to 142 pounds. The prednisone dosage was gradually reduced to 5 mg. per day. Full compensation was attained and thereafter was maintained by a regimen consisting of Neohydrin orally, 18.3 mg. twice daily; Diamox 250 mg. every four to five days or whenever there was a gain in weight of 1.5 to 2 pounds, Digoxin 0.25 mg. once daily, five days a week, and 2.5 mg. of prednisone twice to once a day. Diamox was most remarkably effective, causing a diuresis of 2,500 to 3,000 cc. each time. No injectable mercurials were necessary for two years.

When chlorothiazide became available, it was substituted for the Neohydrin and Diamox without the prednisone because of the patient's objection to it. After two weeks there was again evidence of fluid retention and a gain in weight. A mercurial (Thiomerin 0.75 cc.) was given, and a good diuresis was obtained. Several days later, the patient complained of pain in one leg. There were no objective abnormal signs. About a week later he died suddenly, presumably from a pulmonary embolus.

Comment

The remission achieved with prednisone is, of course, only a remission. The inevitable progression of the basic cardiac disease is not arrested. A grace period, however, varying from months to several years, may be obtained during which time standard treatment can be used again for maintenance of adequate compensation.

I should like to emphasize that prednisone was not given to patients in ordinary congestive failure merely as an adjunct to routine treatment. The accepted contraindications to the use of steroids were observed in all but the desperate cases, and then their use was undertaken as a calculated risk.

I was particularly impressed by the effectiveness of prednisone in the three cases in which broncho-pulmonary disease, asthma, bronchiectasis and emphysema were present. Perhaps the indications for prednisone in cases of congestive failure associated with respiratory disease might be liberalized. It is possible that the improved respiratory ventilation contributed to the salutary effect. Certainly not all the intractable cases respond, and it is still uncertain why some do and others do not. It would be convenient if there were some easy test to determine which cases would respond.[16]

As to the mechanism of the action of prednisone, many explanations have been proposed: that prednisone inhibits production of antidiuretic hormone (vasopressin) by the neurophypophysis, thus decreasing tubular reabsorption of free water;[7,17] that it suppresses production of aldosterone or antagonizes its effect;[15,16] that it has a "general body effect," improving the body's ability to handle salt and water in edema states.[18] My belief is that prednisone promotes a redistribution of electrolytes and water between the various fluid compartments in such a way as to bring about a back shift of salt into the extracellular fluid space making it once again presentable to the kidney tubules for reabsorption. Here saluretic drugs can once again effect diuresis by blocking its reabsorption. Several recent publications tend to support this view.[5,13] Whatever the actual mechanism is proved to be, I believe that sufficient rationale and clinical confirmation of its effect exist for clinical trials of prednisone to be warranted in selected cases of intractable heart failure.

As to chlorothiazide, when the edema becomes refractory because of far advanced myocardial failure, it will not respond to chlorothiazide any more than it will to the mercurials. Under those circumstances prednisone is again a useful agent to help re-establish responsiveness.

Summary

As more cardiac patients in congestive failure live long enough to reach the "intractable" stage, the problem of resistance to treatment is confronting physicians more often. The neurohypophysis and the aldosterone-producing adrenals play a major part in this failure of the homeostatic adjustment mechanisms; this failure results in the intractability of the edema even without overt deviation of extracellular fluid electrolyte levels. In 10 cases, cardiac edema with normal serum electrolyte levels became unresponsive to the usual diuretic measures, including mercurials, chlorothiazide and attempts at induced hyperchloremia and acidosis. This refractoriness was reversed in eight by the use of prednisone in a specific manner and dosage. Attempted explanation of the mechanism of this reversal is made on the basis of transcellular shifts of electrolytes from an electrolyte pool into the extracellular fluid compartment.

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Beginnings of Clinicopathologic Correlation

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"The road to a clinic goes through the pathologic museum . . . " This trenchant dictum of William Withey Gull is now so incorporated in the teaching of medicine that one might presume it was always so. Such is not the case; 5,500 years of recorded medical history passed before this concept was clearly defined.

Probably long before the dawn of recorded history, occasionally the bodies of the enemy were opened in the spirit of desecration. Battle wounds also often provided a glimpse within the body cavities. Later, near the dawn of history in the Nile Valley, the custom of embalming and possibly dissections taught the ancient Egyptians some knowledge of anatomy and pathology. Henry Breasted, in the introduction to his translation of the Edwin Smith papyrus, which dates perhaps from as early as 3,000 B. C., stated that the descriptions of diseases of the internal organs mentioned in this papyrus seem too detailed to have been derived from embalming alone. Anatomic dissections of bodies decomposed by seven days' submersion in water were practiced by the Brahmans possibly before 1,000 B.C. in India. Pliny stated that Herophilus (about 300 B.C.), the keen Alexandrian anatomist, was the first man who dissected bodies searching for the cause of disease. Celsus, about 50 A.D., stated, "I am of the opinion that the Art of Medicine ought to be rationed . . . . to open the bodies of the dead is necessary for learners." In addition to these beginnings, isolated autopsies were carried out during the early centuries of the Christian era chiefly in cases of suspected poisoning. The first clear record, however, of the opening of the bodies of the dead with the express purpose of discovering the cause of death is found in the notes of the Florentine physician, Antonio Benivieni, (1443-1502), which were published in 1507. The manuscript in which Benivieni recorded his notes on approximately 160 cases was discovered five years after his death, and published by his brother under the editorship of the brother's physician, Giovanni Rosati. An English translation of this book, "De abditis nonnullis ac mirandis morborum et sanationum causis" (The Hidden Causes of Disease), was made by Charles Singer and has been recently published by Charles C. Thomas, Publisher, Springfield, Ill.

Although the simple reading of the case reports themselves is sufficient to arouse one's admiration for this physician, some knowledge of the man and the thinking of his times more vividly reveals him as a pioneer in the concept of clinicopathologic correlation. At a time when theorization based on the doctrine of the four humors held full sway in medicine, he opened the bodies of the dead seeking an explanation of the cause of symptoms and death in the anatomic changes visualized there. Antonio Benivieni was born into an ancient and aristocratic Florentine family at the time when Italy was in the renaissance of learning. He received the finest education the world of his time could afford. As a youth he

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had an excellent private tutor and later was enrolled at the Universities of Pisa and Siena.

He was admitted to practice some time prior to his thirtieth birthday and matriculated with the Florentine Guild of Doctors and Apothecaries as a Physician and a Man of Letters. The Florence of his day boasted several notable hospitals; one in particular had 230 beds and was what one today would speak of as "a teaching hospital." Although factual information is lacking, it seems likely that Benivieni frequented this hospital and participated in its activities. It is known that he was a successful practitioner and became a wealthy landowner. He was a member of the most influential and learned stratum of society and an intimate friend of the religious reformer, Savonarola. Yet as a physician he displayed humility in the recording of his observations, a respect for his predecessors as he referred to the teachings of Hippocrates, Galen, Avicenna, Celsus, and Paul of Aegina, and a thirst for knowledge as he sought the hidden causes of disease.

The medical knowledge of his day consisted chiefly of the teachings of Hippocrates, Galen, and the Arabian, Avicenna. Indeed, by chance there has survived among his papers an inventory of his library on Dec. 25, 1487. Among 169 titles are 70 medical works of such authors as Aristotle, Hippocrates, Dioscorides, Pliny, Galen, Celsus, Avicenna, Averroes, and William of Saliceto. Astrology and superstition were rampant in the medical thought of his day as is evidenced in several of the case histories he presented. The surgical authorities of his time were William of Saliceto, Henri de Mondeville, and Guy de Chauliac. Benivieni's knowledge of anatomy seems appallingly inexact at times, but it will be recalled that the study of anatomy had advanced little beyond that of Mundinus who had preceded him by 150 years. Leonardo da Vinci was a contemporary of Benivieni and was at that time performing dissections and making anatomic drawings in Florence, but it is doubtful that Benivieni had access to them.

"De abditis nonnullis ac mirandis morborum et sanationum causis" deals with clinical medicine and surgery; however, in it are recorded 20 cases in which after death "incisions" were carried out seeking the cause of death. The reader may be disappointed at the willingness of Benivieni to accept trivial abnormalities as an explanation for the patient's demise and his, at times, gross misinterpretations of the anatomic findings. Nevertheless, if the reader could mentally divest himself of the large portion of medical knowledge which has been acquired in the last four and a half centuries, he would more charitably appreciate the efforts of this Florentine physician and man of letters. To exemplify Benivieni's method and thoughts, the following three cases are taken from Singer's translation:

III Stones Found in the Coat of the Liver

A woman of noble birth had been for long greatly tormented by pain in the region of the liver. She had consulted many physicians, but could not drive out the evil by any remedy. She therefore decided to try my help in conjunction with some others.

Thus several of us met and discussed at great length from different aspects the hidden causes of this disease. As often happens in doubtful cases, we were divided. Some thought there was an abscess on the liver, others that it was itself diseased, but I personally believed that the fault lay in the covering membrane. A few days afterward the disease took stronger hold and she departed this life, even as we had foretold by common consent from unmistakable symptoms. I then had her dead body cut open. There were found in the lower part of the membrane round the liver, a collection of small stones varying in shape and colour. Some were round, some pointed, some square, according as position and chance had determined, and they were also marked with reddish, blue and white spots. These stones by their weight had caused the membrane to hang down in a bag a palm's length and two fingers wide. This we judged the cause of her death and decided that discussions upon what was hidden were vain and futile.

XXXIV A Nun Who Died Through Pain In The Intestines

In the convent of San Donato in Pulverosa, there was a devout woman, a member of the convent, who had suffered for many months with pains in the intestines. Her bowels, moreover, passed nothing without pain and difficulty and that only every tenth day. No remedies available. She was burdened long and grievously by this disorder till at last she died.

I had the body cut open and found the intestines contracted by a thick callus so that only a narrow channel was left and the excrement could scarcely pass through. This however I had suspect-

ed even in her lifetime, seeing that she had struggled against something hard that pressed on her bowel.

LXXX WOMAN CURED BY EXTRACTION OF STONE

It is established that stone develops in women as well as in men. A nun went without passing urine for twelve days, the urinary passage being occluded by a stone, round which much matter had collected. As this could be dealt with neither by a bronze catheter nor by drugs, I followed a course unusual in some respects but none the less opportune. I seized the stone with a hook to prevent it from returning to the bladder when struck. Then I banged the stone with an iron instrument with the front part blunt until after repeated blows it was broken into small pieces. Then, with all possible care I could, so as not to damage any internal organ, I drew out the hook and iron together. By this the urine and the stone were together released and the woman immediately cured.

Antonio Benivieni died at the age of 59, but the method of investigation recorded by him was further pursued by such men as: Donati, von Grafenberg, Glisson, Willis, Vesalius, Columbus, Fallopius, Fabricus, Fernel, Riolan, Harvey, Wepfer, Brunner, Bartholin and many others. In 1679 Theophilus Bonetus (1628-1689) collected and published the observations of Benivieni and these men together with his own observations in his "Sepulchretum sive anatomica practica." These 3,000 case reports, however, are also brief and incomplete, and it is the publication in 1761 by Giovanni Battista Morgagni (1682-1771) of 700 carefully documented clinical and pathologic records in his "De sedibus et causis morborum per anatomem indagatis" that is generally considered the foundation of the science of pathology.

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A New Treatment for Cutaneous Larva Migrans

Employing Oral Promethazine

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Cutaneous larva migrans (creeping eruption, sandworm disease, or "muck worm") is widespread in many regions throughout the world, and in this country is common on the Atlantic coast from southern New Jersey to the Florida keys, and along the Gulf of Mexico. The warm, moist climate and sandy soil of such areas appear to supply optimum conditions for development of the larval nematodes that cause the lesions. Cases of larva migrans have been observed as far west as Dallas and San Antonio, Texas, and have appeared in scattered localities elsewhere in the United States. The eruption is particularly troublesome in Florida.[1,2] In one survey[1] more than 8,000 cases were reported by Florida physicians over a six month period, and upward of 500 cases were seen in Jacksonville alone during a 10 day clinic.[1] Knox[3] believed that the annual toll amounts to one in every 2,000 persons who visit the Mississippi Gulf coast (which may account for the spread of the infestation to distant points). It is probable that three times as many cases occur as those that appear in public health reports, since many victims do not consult physicians but attempt to treat themselves.[1]

The disease is of varied etiology,[4] since the larvae of several different species of helminths and of certain flies (Gasterophilus, Hypoderma), ants and mites are capable of penetrating the skin and producing similar eruptions.[1,2,4,5] The most frequent causative agent, however, is the third stage or filariform larva of several species of animal nematodes, including Ancylostoma braziliense, the common hookworm of dogs and cats, and of the human hookworms, Ancylostoma duodenale and Necator americanus. Other species cause symptoms occasionally, as Uncinaria stenocephala, of dogs; Gnathostoma, of pigs; and, rarely, Bunostomum phlebotomum, of cattle. Multiple infestations by several varieties may occur. The eggs of the roundworms are excreted in the animal feces and infective larvae hatch in the soil. Children may be frequently exposed. Carithers[6] emphasized the public health importance of

controlling worm infestations in animals kept around the home, especially since children usually live in intimate contact with family pets.

The hands, feet, back, buttocks, perineum and perianal regions are the most frequent sites of infestations, but the larvae may invade the skin of any part of the body, and persist indefinitely. Red papules develop at the site of penetration after some hours or days,[1] and as the larvae burrow between the stratum germinativum and corium, in a tortuous, meandering course, the skin over the tunnels is at first erythematous, then becomes elevated and vesicular. The worms progress through the dermis at a daily rate of several millimeters[2] and are always located at some distance ahead of the visible burrow, which is one reason why topical measures are so seldom successful.

The movement of the worms induces severe inflammatory reaction in the tissues, with intense itching, which stimulates scratching, with the risk of secondary infection. Several observers have suggested that the eruption may be, in part, a manifestation of sensitization.[4] Animal hookworms that have invaded the skin may subsequently migrate to deeper tissues and eventually penetrate the viscera, may persist for varying periods, and occasionally may reappear in the skin weeks or months later. Infective larvae of Ancylostoma caninum have existed for prolonged periods in the tissues of experimental animals and have produced prenatal infections.[4]

Diagnosis is presumptive, and is based on the presence of the typical pruritic burrow. Identification of the invading species is extremely difficult.[7]

Common as the eruption is, all treatments so far suggested have been unpredictable, extremely satisfactory and usually distressing. Any therapy, to be successful, must destroy the worm itself. Systemic measures employing various anthelmintics have produced indifferent results, even when used in repeated courses. Salicylic acid in various bases, and antimonial compounds, as Fuadin, generally have been useless. Piperazine has been recommended, but the effect of this compound on helminths other than Enterobius and Ascaris seems doubtful;[8] yet almost all physicians treat roundworm-infested patients first of all with piperazine. Local measures, as excision, injection of procaine or chloroform into the burrow, or application of electrodesiccation, have been equally disappointing. Topical agents capable of killing the larva will also cause more or less extensive damage to the skin. Application of carbon dioxide snow is hazardous. Injudicious freezing of the burrow by the untrained victim, using ethyl chloride, the agent he is most commonly able to obtain for self treatment, has been responsible for severe burns.

Since the first report, by Campbell and his co-workers in 1934,[9] of the lethal action of phenothiazine against certain mosquito larvae, many others have studied the anthelmintic properties of the compound. DeEds and Thomas[10] demonstrated fungicidal and anthelmintic activity, and bactericidal action in the urinary tract. Findlay[11] reviewed the subject and directed attention to the report, by Harwood, Jerstad and Swanson, in 1938, that small repeated doses, each in itself too small to cure, controlled the development of roundworms in swine and reduced production of eggs by the parasite. Davy demonstrated in 1942 that phenothiazine does not penetrate the cuticle of the nematode, but acts only after having been ingested by the worm. Although valuable in veterinary practice, phenothiazine has been considered too toxic for the human host.

It occurred to me that promethazine, a closely related derivative which had been used for several years solely as an antihistaminic, might have anthelmintic possibilities. The extremely low toxicity of the compound had been amply demonstrated in numerous pharmacologic and clinical studies. Three unsuccessful suicide attempts employing massive doses of promethazine have been reported;[12-15] there were no subsequent ill effects. I therefore decided, in early 1957, to try promethazine for the patients in my private practice who required treatment for larva migrans.

Description of Series

To the date of this report, 57 patients suffering from creeping eruption have been treated exclusively with promethazine by mouth. To young children, the compound was administered as a syrup,* to older children and adults, in tablets of 25 mg.* The group included both sexes. The youngest was a child of 14 months, the oldest a 68 year old man. Various parts of the body were involved, the extremities, back and perineum most frequently.

Because of the varied etiology of the disease, and the widely differing species responsible for

*Phenergan, promethazine hydrochloride [N-(2'-dimethylamino-2'-methyl) ethyl phenothiazine hydrochloride], available from Wyeth Laboratories.



Fig. 1 A.—Multiple points of entry on buttocks and thighs. Most of the lesions are red, raised, tender, pruritic and furuncle-like. A few show the typical meanderings of the larva. B.—The same patient five days later, after one course of promethazine. The lesions are fading, and the burrows have almost disappeared.

symptoms, the dose cannot be standarized. Each case must be managed individually. I began, in the early cases, with a smaller total dosage than that used now, and gradually increased it as I gained confidence with the method. In general, young children, up to six years old now receive 50 mg. at bedtime; older children, 75 to 100 mg. and adults, 150 mg. or more, according to body size and severity of the infestation. The medication is administered in the same amount nightly throughout a course of three successive doses.

If in this series the first dose did not produce immediate relief, the second was increased by 50 per cent. Occasionally it has been necessary to repeat the three dose course. For example, one adult showed no response to 250 mg., administered on three successive nights. The course was then repeated, employing three nightly doses of 400 mg. with success.

Results

The most remarkable finding was the complete cessation of pruritus after the first dose in all cases, after I began to increase the amount. At the same time the angry red hue of the raised skin over the burrow began to fade. The burrows disappeared and healing was complete in three or four days (fig. 1.). In the total series, treatment has been successful in 89.5 per cent of the cases. The eruption has not recurred after disappearance in any case. The first course usually kills all the larvae.

There were six treatment failures (10.5 per cent) in the early part of the series, when smaller doses were used. It is possible that had a larger total dosage been administered, and perhaps the course extended to the fourth day, these patients, too, might have responded satisfactorily.

An interesting observation was that as long as the invaders remain at the site of entry, there is apparently enough inflammatory tissue reaction to impede penetration of the compound to the parasite itself. When migration begins, however, the destructive action of promethazine upon the worms is reliable. Thus a smaller total dosage suffices for elimination of actively burrowing larvae.

Clinical studies are hampered by the paucity of information available on the characteristics of the worms themselves. In the presence of long-standing eruptions probably caused by multiple infestations, differences in species sensitivity to promethazine may be a factor in the susceptibility or resistance of the patient to treatment. Thus in some cases a greater blood concentration of promethazine may be required for therapeutic efficacy.

Discussion

The soporific properties of promethazine, which are entirely separate from the activity of the compound upon the worm, were an advantage to these patients, since insomnia from the intense itching is one of the consequences of cutaneous larval infestation. All who experienced a satisfactory result slept soundly throughout the night from the time of the first dose.

Six experienced nightmarish dreams while under treatment, and of these four exhibited a hyperexcitable reaction on the night of the first dose, which was not repeated with succeeding doses. The exact reason for such reaction is not known at present. It is common knowledge, of course, that severe visceral helminthiasis may produce central nervous system disturbances. Sisk[15] described nightmares and nocturnal excitement as the third most frequent symptom of enterobiasis in untreated children, and other parasitologists suggested that such reactions during treatment of heavy infestations may reflect the absorption of toxic products after rapid destruction of large numbers of the worms. Occasionally, similar nervousness and excitement may occur after administration of barbiturates.

Among the early reports of use of promethazine in parenteral medication before operation, it was observed[16] that in some patients a phase of agitation resembling the second stage of nitrous oxide–oxygen anesthesia followed the injection, and that such symptoms disappeared promptly on administration of additional doses of the compound.

The patients in this series who exhibited such a reaction fell asleep after the first oral dose, awoke later and wandered about, apparently in a somnambulistic daze, for a short time. Rarely, in patients under promethazine treatment for worm infestation hyperexcitability may occur. A second dose in the same amount as that given initially will promptly control the reaction.[17] When forewarned of such a possibility, patients' families will not be disturbed by the occurrence.

Cases Illustrating Initially Resistant Infestations

A 14 month old boy, suffering from severe larva migrans of the foot, was first seen after having experienced symptoms for two months. Promethazine was administered orally, in doses of 25 mg. at bedtime, for three nights. There was no improvement. The dose was increased to 37.5 mg. per night in a second course. The eruption was completely cured.

A 44 year old white man was first seen with severe larva migrans on the back of one hand. He had treated himself by freezing the eruption with ethyl chloride, and inflicted two degree and three degree burns, but the worms were not affected. After medication with 125 mg. of promethazine per night for three nights, the itching subsided. One worm resumed activity the second day after completion of the first course. A second course of treatment, employing 150 mg. per night for two nights accomplished complete cure.

A 16 month old boy was first seen suffering from a severe eruption caused by several scattered migrating worms. One course of promethazine, 25 mg. for three nights, killed two of the worms, but the others were unaffected. A second course of 50 mg. of promethazine per night for three successive nights destroyed a few more larvae, and an additional course of 75 mg. eliminated the infestation.

Summary

Fifty-seven patients suffering from cutaneous larva migrans were treated solely with promethazine by mouth in varying dosages. In general, children up to six years of age now receive 50 mg. at bedtime, older children 75 to 100 mg., and adults 150 mg. or more. The dose is repeated on three successive nights, and occasionally an additional course is given in the same or increased dosage.

The eruption was eliminated in this series, with prompt relief of itching and disappearance of erythema after the first dose, in 89.5 per cent of the cases. In the resistant cases (10.5 per cent) the patients were treated early in the series, and it is probable that the smaller doses used at that time were inadequate.

The method is simple and safe for general use, and is worthy of further trial.

The hyperexcitability that patients may experience in rare instances after ingestion of the first dose may be controlled by an immediate additional dose of the same amount, and is not a contraindication to use of this compound.

Such medication brings the treatment of larva migrans under a rationale comparable to that for the control of other types of nematodiasis with chemical vermifuges. Perhaps equally important is the fact that use of promethazine returns the management of this common affliction to the hands of the physician.

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Syringocystadenoma Papilliferum

Case With Large Rapidly Growing Lesion

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Syringocystadenoma papilliferum is an entity that is most commonly discussed in the dermatologic literature, wherein it is also referred to as "syringadenoma papilliferum," "nevus syringadenoma papilliferum," and "nevus syringocystadenomatosus papilliferus." This lesion of sweat glands should be considered in the differential diagnosis of solitary verrucous or papillary growths, but not infrequently it is misdiagnosed. Sometimes the clinician may have the impression that he is dealing with a malignant neoplasm or a malignant change in a previously benign growth, especially since some of the lesions grow rapidly in the few months prior to surgical removal. This was the situation in the case reported herein, which is of particular interest also because of the large size of the lesion.

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Report of Case

The patient was a 39 year old Negro man in good health. More than two years previously he had noticed a small wart-like lesion in the middle of his back. It grew slowly in size, but in the past two or three months had grown rapidly. It was annoying because of its size, but not painful.

General examination revealed no abnormalities. The only lesion was in the upper midback. It was a large, irregular, elevated tumor, measuring about 10 by 5 cm., and was elevated about 5 cm. above the skin (fig. 1). The surface was irregular. In some areas it was apparently covered by normal skin and in others by what appeared to be dry granulation tissue. The tumor was firm, and although somewhat pedunculated, it was attached to the underlying skin by a firm base. This mass was insensitive to pressure and to sharp instrumentation. Painless biopsy was accomplished without anesthesia. The growth was movable within the limits of the rather taut skin present in this area. No lesions were noted elsewhere.

The diagnosis of syringocystadenoma papilliferum was made only by examination of the biopsy specimen. At operation, removal was accomplished by wide transverse elliptic excision. The base of the tumor and subcutaneous tissue were removed down to the deep fascia. Closure of the large skin defect was obtained by extensive undermining and widely placed wire tension sutures which were left in place 20 days. At the time of this writing, 14 months after operation, there has been no sign of recurrence.

GROSS EXAMINATION OF SPECIMEN.—The specimen consisted of an irregular, polypoid mass attached by a broad base to a portion of skin. It measured 10 by 5 by 5 cm. The outer surface, for the most part, was granular with whitish areas. The tumor was firm in consistency. The cut surface showed multilocuated, smooth-walled cysts containing a dirty, brownish fluid (fig. 2).

MICROSCOPIC EXAMINATION.—Sections showed a large polypoid, papillary and cystic skin tumor (fig. 3). There was a gradual transition from hyperkeratotic, acanthotic epidermis to an intricate papillary structure that extended deeply into the lesion, the center of which was occupied by large dilated cysts. The papillae were plump and lined by two layers of cells (fig. 4). The inner layer was composed of small, compact cuboidal cells with a moderate amount of homogeneous eosinophilic cytoplasm and dark, round nuclei. The outer layer, which was usually single, but occasionally stratified, was composed of large cuboidal to columnar cells consisting of scanty amphophilic cytoplasm, that was occasionally being extruded at the surface, and large ovoid vesicular nuclei. The stroma of the papillae was composed of hyalinized fibrous connective tissue containing numerous dilated blood vascular spaces, and infiltrated by numerous plasma cells (fig. 4). Some papillae were capped by stratified squamous epithelium. The large central cysts were lined by flattened cells that showed remnants of the double epithelial lining. Adjacent to one edge of the tumor there was a small group of ductal structures lined by stratified squamous epithelium and containing loose cells and amorphous eosinophilic debris. No evidence of basal cell carcinoma or nevus sebaceus was seen. An abundant margin of uninvolved skin and subcutaneous fat was seen at all edges of the specimen.



Fig. 1.—Clinical appearance of the polypoid, verrucous lesion arising from the skin of the back.

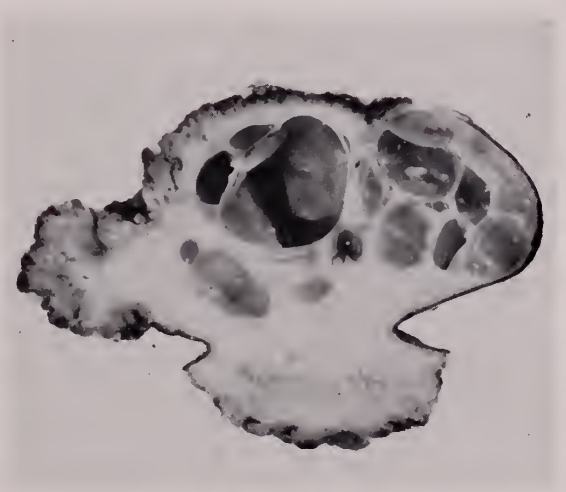


Fig. 2.—Cut surface of surgically excised specimen showing elevated, polypoid, cystic lesion. The normal skin from which it arises is at the bottom of the figure.

Comment

Syringocystadenoma papilliferum is regarded as an adenoma arising from ducts of sweat glands,[1] although there is some difference of opinion as to whether it is of apocrine or eccrine origin. It is not our intention to summarize all the literature concerning the histogenesis of this lesion. The various concepts of histogenesis, as well as a general discussion and review of reported cases of this growth, can be found in the articles by Helwig and Hackney,[1] Pinkus,[2] and Lever,[3] which will serve as a basis for the following comments.

In an analysis of benign tumors of the cutaneous appendages, Lever[3] supported the theory that syringocystadenoma papilliferum is an apocrine adenoma on the basis of his observations on six cases. Pinkus[2] studied and presented 31 cases in an attempt to analyze the life history of the lesion. He suggested that most of the tumors of this type are related to apocrine glands, but that in a few cases origin from eccrine glands may occur. Helwig and Hackney[1] concluded that this lesion probably arises from eccrine glands which are so altered that they are no longer identifiable as eccrine or apocrine, or that, more likely, it arises in a gland intermediate between apocrine and eccrine. They based this conclusion, at least in part, upon the fact that "ninety of the 100 sweat gland lesions reported here were on body surfaces where apocrine glands normally do not occur. In contrast, no lesions were in the axillae, areas known to be rich in apocrine glands. In 58 instances, the lesions were said to have appeared before the 10th year of life, a period when apocrine glands are rarely, if ever, recognized." In the reports of syringocystadenoma papilliferum, there

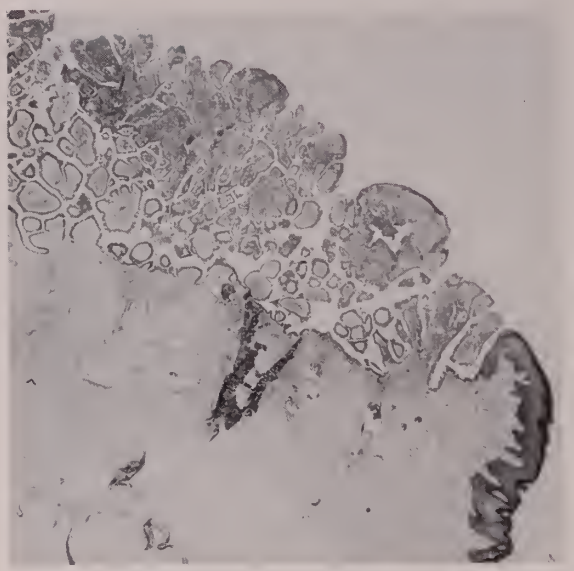


Fig. 3.—Microscopic appearance of one area of lesion, with adjacent normal skin on right. Papillomatous nature is apparent. Cysts are present at base of photograph. Hematoxylin-eosin stain. X23.

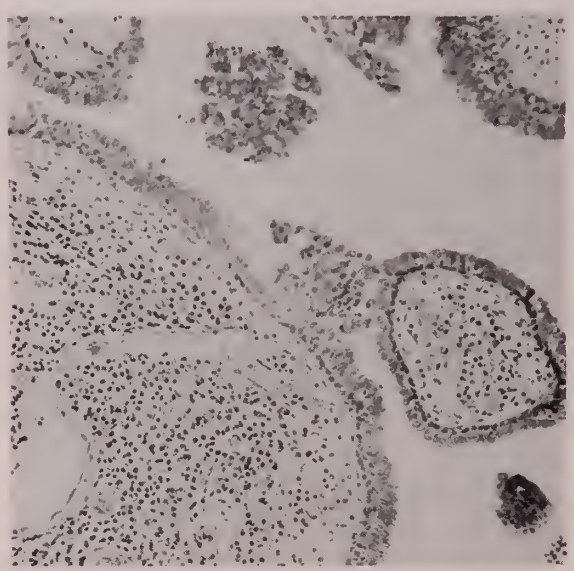


Fig. 4.—Detail of plump papillae with double-layered epithelial surface and numerous plasma cells of stroma. Hematoxylin-eosin stain. X416.

is commonly noted in association with this lesion a hyperplasia of the sebaceous glands (called "nevus sebaceus" by the dermatologists). Less commonly, there is sometimes an associated basal cell carcinoma. The coexistence of these lesions is responsible for the concept that this adenoma of sweat glands develops in a hamartomatous malformation of the skin.[1,2,3]

Clinically, syringocystadenoma papilliferum is present frequently at birth, but may appear at any age in childhood or adult life. It is usually a single lesion. In the series of cases presented by Helwig and Hackney,[1] the lesions varied from an irregular, flat gray or red, nevus-like area to a gray or dark brown, elevated papillary or verrucous growth which was hyperkeratotic or at times moist and fleshy. Sometimes, they noted round and smooth lesions, or an occasional one that was pedunculated, smooth and bulbous, and rarely one that was represented by an elevated, umbilicated area. Occasionally, clear or brownish fluid was seen exuding through a pore in one of the verrucous or bulbous lesions.

The size of the growths varies. In the cases of Helwig and Hackney[1] they ranged from 1 to 4 cm. in diameter. In Pinkus' series of cases they ranged from 1 to 5 cm. in the greatest diameter, although two of them were larger, being 7 by 3 cm. and 10 by 3 cm. The lesion in our case was only slightly larger than this latter one, measuring 10 by 5 cm., which is large for this type of sweat gland adenoma. As proved microscopically, the entire growth consisted of the adenomatous lesion with rather large cystic ducts beneath the papilliferous part, and no associated "sebaceous nevus" nor basal cell carcinoma was evident.

The most common location of syringocystadenoma papilliferum is the scalp.[1,2] Other frequent sites are the forehead, temple, face, back, abdominal wall and inguinal region, but other areas of the skin may be affected. Apparently the axilla is not a common site for the development of this lesion. Pinkus[2] listed one such case in his series, but Helwig and Hackney[1] were impressed with an absence of the lesion in this region in their cases.

The microscopic appearance of this adenoma is distinctive and generally should not be confused with other lesions. The papillary projections covered by the typical double-layered epithelium are striking. Underlying ductal structures, sometimes cystic as in our case, lined by a double layer of epithelial cells or by flattened epithelium, are frequently present. Many lesions contain numerous plasma cells in the stroma as was noted in the present case. While this is a characteristic feature, the true significance of the plasma cell infiltration is still in question, although several explanations have been suggested in the literature.

In addition to the rather large size of the sweat gland adenoma in our case, another feature of interest is the rapid growth it underwent in the few months prior to surgical removal. Generally,

as noted in the reported cases, this lesion tends to grow and enlarge slowly over a period of years, but in a few instances it has been observed to grow to considerable size in a few months.[1] Because of this rapid growth, the clinician may be misled and may suspect that a malignant neoplasm has developed. He may not be certain of the diagnosis until the pathologist has made a microscopic examination of a biopsy specimen or of the excised lesion.

Syringocystadenoma papilliferum is a benign growth. Recurrence after surgical excision has been observed,[1,2] presumably because of incomplete removal. Pinkus[2] indicated that complete cure "can be expected only if the entire involved area is excised through the full thickness of the skin, including that part of the subcutaneous fat which contains the deep-seated apocrine coils." Even after this thorough excision, he further observed, "recurrences or, rather, development of new lesions in the same area was reported by some authors." Malignant change in this lesion is apparently rare. The case of Hedinger[4] is cited, in which it is said that the malignant sweat gland tumor of the scalp, which metastasized to the lymph nodes, probably arose in a syringocystadenoma papilliferum. As mentioned, basal cell carcinoma sometimes develops in association with syringocystadenoma papilliferum.

Summary

Syringocystadenoma papilliferum is a distinctive form of adenoma of sweat gland origin. It should be considered clinically in the differential diagnosis of solitary, verrucous or papillary lesions of the skin.

A case is presented in which the lesion, one of remarkably large size that grew rapidly in the few months before surgical removal, was suspected of being possibly malignant.

The concepts of histogenesis, and the clinical and pathologic features of syringocystadenoma papilliferum are briefly reviewed.

The authors are grateful to Mr. William Atkinson for the photographs.

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A Pilot Study in Group Weight Control

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Losing weight is always a popular topic of conversation. At one time or another, almost everyone has talked about taking off a few extra pounds. Lately there has been expressed interest in a new way to "fight the battle of the bulge" called the group method of weight control.

What is this group method? How does it work? Does it really help people lose weight? These are some of the questions I shall attempt to discuss in the light of a pilot program in weight control established by the Dade County Health Department during the summer and fall of 1957.

The Health Department was approached through the nutritionist with a request for help in reduction and control of weight by a group of community women. These grossly obese women had organized into the Pounds Eliminated Properly Club, or the PEP Club as they called themselves, for the purpose of losing weight. This club had functioned for three years, meeting on a weekly basis and on its own initiative. As one of the members expressed herself, "After meeting all of this time without getting anywhere, we realize our need for supervision."

Since it has been proved beyond doubt that in overweight persons heart disease, diabetes and many other illnesses tend to develop earlier and more frequently than in persons of normal weight, the Public Health significance of the obesity problem is apparent. A committee, composed of the Dade County Director of Maternal and Child

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Read before the Florida Health Officers' Society, Bal Harbour, May 11, 1958.

Health, the Director of Public Health Nursing, the Public Health Educator, and the State Nutrition Consultant, was therefore set up to review request.

The committee concluded that a service could be rendered to this group with the ultimate goal of projecting a community-wide weight control program in the future. Recommendations were made by the committee for a workable program of procedure. They were:

"1. Since the program is of an educational nature, it is felt that the name should be altered to PEP Class rather than Club.

"2. It is suggested that classes be limited to twenty (20) members as it is felt that this number constitutes an optimum group for such purposes.

"3. Assuming that the true motives for participating in a weight control class are the actual loss of excess weight and the maintenance of normal weight, the awarding of prizes for weight loss should be eliminated.

"4. In order to insure general good health, a physical examination and approval by a qualified physician are required for membership in the class.

"5. The class meets on a bimonthly basis for a series of twelve (12) classes with the date, time, and place of meeting determined by the membership.

"6. Program topics should be planned to include an over-all approach to the problem of weight control. The Health Department will cooperate, drawing on community resources when indicated, i.e., physicians, nutritionists, mental health workers, educators, etc.

"7. At the end of the series an evaluation will be made from the viewpoints of both the participants and the Health Department."

These recommendations were presented to the PEP Club at their regular meeting, and 19 members indicated an interest in actively participating in the program. Of this number, 13 had been members of the Club for a period of one to four years. The weights ranged from 143 pounds to 251 pounds at the beginning of the study, the average being 182 pounds. The members indicated that each had been on a dietary regimen of some type, and all of the group had tried one or more of the popular "miracle" weight reducers such as drugs, cellulose wafers and passive exercise.

A follow-up meeting was arranged by the Health Department in which representatives of the group met and outlined a program planned to cover the medical, psychologic and nutritional aspects of weight control. Also, thought was given to menu planning, exercise, and personal grooming. The twelfth and last meeting was set up for a final group evaluation of the six month series of programs. The members were urged to express their feelings freely in order to enable the Health Department to evaluate better the total study.

Evaluation of Results

Among the many ways of testing the degree of success of a particular method used in weight reduction are (1) simple measurement of the pounds lost, which has obvious limitations; (2) calculation of the percentage of overweight lost, both inadequate and unfair in that it places a disproportionate burden on those most overweight; and (3) comparison of actual loss in weight with expected loss as outlined by Jolliffe in his Performance Index. The Index is merely a projection of expected loss in weight over a period of time at various caloric levels. This is reliable and should be adopted for the evaluation of weight reduction programs in order to compare results of research throughout the country. Unfortunately, we were not familiar with Jolliffe's work at the beginning of our study.

In terms of loss in weight, 11 persons lost a total of 127 pounds, or an average of 11.5 pounds. Six persons gained a total of 46.75 pounds. Two members dropped out before the classes were completed.

As a partial solution, and upon an urgent request, group therapy was offered to those who thought they could benefit. A psychologist is now meeting regularly with this small subgroup of the larger class.

It might be of interest to note representative comments that resulted from the evaluation meeting. Here are quotations directly from the members.

"I enjoyed the course, but every other week business isn't any good. Every week would be much better. The group helped me to lose weight." Beginning weight 170; ending 159.5.

"The health group didn't do me much good. I never really got on a diet. I find it hard to really get started on a diet and that is my trouble. I think the health group program wasn't too well organized." Beginning weight 176; ending 182.

"The group has helped me a great deal and is a very good thing, but the girls didn't take it as

sincerely as the department of health would have liked us to." Beginning weight 210; ending 195.

"I was very much honored that the educated people came and worked with us to help us lose weight. But I don't feel that they took enough interest in each person as a personality. They didn't check up on us close enough." Beginning weight 203; ending 185.

The group summarized their own comments as: "It is mostly our fault because we didn't cooperate fully, but the space of time between meetings and lack of individual attention seem to be the main reasons. However, we would like to join another similar group if you form one, but it would have to be every week."

In other words, each one is saying, "We need someone to make us lose weight and appreciate us as an individual."

Need for Preventive Programs of Weight Control

Upon evaluation of the program by the Health Department committee and with guidance from Dr. Margaret Hartly, private psychologist, it is realized that the small numbers involved and the history of this group prevent valid and authoritative conclusions. There are trends, however, which would indicate an urgent need for preventive programs of weight control.

1. From an educational standpoint, it is believed the best results were obtained from a group discussion technic without a set pattern of content.

2. The crucial role of motives for dieting was recognized and calls for further study and evaluation.

3. It was generally agreed among the committee in most cases that the probable motivating factor in the organization of the PEP Club group was a need for social outlet and group acceptance rather than a paramount desire for reduction in weight.

4. Our observations, although inconclusive, seem to indicate that for some of the more rigidly dependent personalities, there was a high emotional risk in removing their obesity without attempting to correct or alleviate underlying personality and psychiatric problems.

5. Methods and technics for working with overweight people in groups are of value. In addition to the saving of staff time, such technics also provide an efficient means for giving accurate information in answer to specific concerns about overweight and dieting.

6. Discussion with the participants, both those who lost significant amounts of weight and those who did not, tends to support the impression that the group experience helped all of the members of the group in some way, although in some cases the specific problem of obesity was not solved. It is our impression, however, that the benefits received by this pilot group and the results accomplished did not warrant the amount of time and effort expended by Health Department personnel in a program of this type.

1200 Southwest First Street.

ABSTRACTS

Effect of Nitrofurantoin (Furadantin) on Morbidity After Transurethral Prostatic Resection. By Louis M. Orr, M.D., W. R. Daniel, M.D., James L. Campbell, M.D., and Miles W. Thomley, M.D., J. A. M. A. 167:1455-1459 (July 19) 1958.

The effectiveness of routine prophylactic chemotherapy was studied in a series of 183 patients after transurethral prostatic resection. A group of 53 patients received 100 mg. of nitrofurantoin (Furadantin) four times a day for two weeks; a group of 43 received half that dosage; and the remaining 87 were treated without this drug. Nitrofurantoin was found by tests in vitro to have the widest range of antibacterial activity of the 11 agents tested in this study. Nevertheless, fever occurred postoperatively with nearly equal frequency in all groups, and there was no significant difference in the degree of pyuria among the three groups six to eight weeks after operation. Extensive study of the bacterial species involved showed Pseudomonas species to be the organism most frequently encountered. Neither this organism nor Staphylococcus aureus was suppressed by the nitrofurantoin, but all the other organisms showed a decided decrease in incidence.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE



A Loaf of Bread . . .

A Jug of Wine . . .

And *Thou*

Omar, with the foresight of an old campaigner, surrounded himself with all the physical impedimenta necessary for the appeasement of his appetite for food, drink and romantic dalliance. It is an inviting and idyllic picture that is painted for us. So far, the poet—the rest of the scene—can come only from our own conjecture. It seems certain to me, however, that Mr. Khayyám would hardly have failed to take full advantage of the situation which he had so carefully set up; and that, as a practical philosopher, as well as a poet, he would extract from it all its utilitarian benefits, while simultaneously indulging his own desires and "pleasuring himself."

The "Thou" of Omar's acquaintance was, if we may judge by illustrations in contemporary editions of the poem, a most beautiful and entirely desirable young lady—and I am sure that a gentleman of the poet's perspicacity could not fail to realize the economic folly of selfish monopoly of Thou's charms, and of employing her solely as his Personal Tranquilizer.

As I reconstruct the picture, Thou constituted a one-woman auxiliary who functioned in a dual role of companion and public relations director par excellence. I can visualize a situation in which, toward the end of a particularly hectic week in the office, the boss suggests to Thou that they take off for a long weekend at that little place in the country where he can completely relax. There, while her cool hands soothe his fevered brow, he can vent his spleen, expound his problems, and expose to her intuitive inspection the difficulties which have harassed him. And I rather imagine that, having done this, he can forget most of these problems, leaving them to her competent, efficient management. And so, on Monday morning when the shop opens again, there is a "new man" behind the boss's desk, and out in front the same charming and disarming smile that protects him from the world while extolling his virtues far and wide.

I am sure that Thou knew all the important Thees and Thous in her community, and that the Thees' hes, in particular, paid close attention to her. I am equally sure that, while Omar understood the importance of all this and Thou's value to him, we, the physicians of Florida, have failed to utilize the comparable potential of our lovely Thous.

And if you think that this is a sneaky way to introduce the subject of the Auxiliary to the Florida Medical Association, let me remind you that it is no more sneaky—and far less effective—than the many devices which its members can use to the benefit of our profession within the State. Already we are indebted to these gals, who love us and are stuck with us, for countless valuable contributions to organized medicine. Certainly I do not need to extol to you their individual charm and loveliness. Let me, however, remind you of their collective force and potential. And let me further urge you to make them your real partners—not in the practice of medicine—but in the promulgation of a doctor's way of life, and in the accomplishment of those things which will perpetuate our heritage, our hopes and our ideals.

So—each of you—encourage, if you will, your own Thou to make her County Auxiliary meeting—held, perhaps the same night as your own—and encourage all the Thous in your particular Auxiliary to feel that they are a part of your organization. Don't neglect nor disparage their efforts—but instead let them know the gratitude we feel for what they have done, as well as the need for what they can do. Let us take a leaf from Omar Khayyám's book and have them beside us in this wilderness. Let us really use them to carry the torch which we can light—and let's don't underrate them. After all, they are still the best apple-merchants in the world. God bless them all . . . especially *Thou*.

J. W. Annis

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"To Thine Own Self Be True"

The beginning of a new year is the traditional time for stock-taking, reviewing past accomplishments, and preparation for the problems ahead. It is a custom highly recommended to physicians, and it should not be confined to the rigorous financial review made necessary in order to fill out income tax forms. Every physician should take time for sober thought on the problem of where physicians and the practice of medicine now stand in a society that has undergone many recent changes, and where it should and will stand in the future. It would be easy as well as trite to say we stand at a crossroads, and have a choice of turning to the right, or left, and perhaps even of taking a middle road. If we have such a choice, most physicians will probably lose little time in taking the road to the right, because they believe this direction is best in both the political and in the moral sense. They believe that it will provide the most favorable milieu for the practice of medicine and for the care of the health of the people for whom they are responsible.

It is doubtful though if we have such a simple choice. It is doubtful that the course ahead of us is so plainly marked; and worst of all, it is doubtful to what extent the medical profession will be able to influence the direction and character of medical practice in the future. The medical profession is not the only group in today's complex society which faces the danger of having its future decided for it. Neither, unfortunately, is it the only group interested in the character of medical practice in the future. The medical profession makes up a small but important part of a large mass of human beings in a society which is moving rapidly over an uncharted course towards the future. The course being followed, and the changes of direction in the future, have been and will be determined by the summation of desires and aspirations of all the components of our society.

Everyone is in favor of good medical care for everybody. Everyone is in favor of better medical care for everybody. The fact that the best medical care in all history is now available and that, in spite of some imperfections, its benefits are more evenly distributed among all classes of people than ever before is perhaps appreciated by some people outside the medical profession. This very fact,

however, has made our profession a potential victim of its own accomplishments and success. It has whetted the appetite of the consumers of medical care for even more dazzling results. This attitude is not surprising in an age when the talk is of trips to the moon, the planets and even to the stars. The public has difficulty in imagining such enterprises in a world where mental illness, heart disease, arthritis and other similar human ills still exist. It feels that the human race must speedily rid itself of all its debilitating and crippling diseases which keep many of its members homebound, since it is no longer to be earthbound. It has visions of an Elysium where there will be no illness, no suffering, and possibly no death; until, like Doctor Holmes' wonderful one-hoss shay which ran a hundred years to a day, the human body goes to pieces all at once.

Physicians, however, unlike the space scientists, are too conservative and possess too much humility to promise any such accomplishments; and perhaps for that reason they face a determined effort to transfer the management of their affairs outside the profession. They properly view such a prospect with alarm because they believe that with such a change the quality of medical care may undergo a cataclysmic decline. They are sure that the groups seeking such a change are ignorant of the complex means by which, and the painstaking and delicately balanced media in which, the best medical care can be given.

The medical profession cannot, however, afford proudly to ignore these pilgrims to Elysium. It cannot be guided altogether by its hurt feelings toward the "what have you done for us lately" attitude. It cannot afford to develop a paranoid reaction toward all groups who themselves show hostility in their efforts to improve us. Our policy should be based on the frank recognition of the fact that all segments of our society will have some voice in determining our future. While it is obvious that much of our future will be determined at the polls, it is not enough for each physician to occupy himself only during the few weeks before elections. The interest and effort of every physician in the future of medicine should be constant and continuing. We should study each issue affecting our profession in the same detached and thorough manner as we study the problems of our patients. We should concede the possibility that some good ideas affecting us may come from without the profession, and support such ideas when this is true. We should, however, continue to oppose proposals which would regiment physicians, and which would lessen the freedom of the individual physician to uphold the highest standards of medical practice that have been developed over the years. We should explain our views daily and patiently whenever an opportunity presents itself.

Obviously, such efforts will be more productive if aimed at persons and groups not already sympathetic to our views and problems. Special efforts should be aimed at middle and low income groups, and at groups with fewer educational advantages. We will be wasting our time in trying to convince groups that are already convinced. It is essential, too, that physicians listen to the views of others. The ancient dialogues of Plato show that Socrates won his arguments by allowing his opponent to talk most of the time which always resulted in his convincing himself that he was wrong and Socrates right. Also, physicians should remind themselves of the timeless advice given by Sir William Osler on equanimity. He counseled that physicians be tolerant and equanimitable when their favorite patient is found placing reliance on a notorious nostrum.

The medical profession and related groups, the vendors of medical care, make up a small minority of the general public as compared to the consumers of medical care. We cannot afford to feel or show animosity towards the consumers because these are our patients and our charges. We must exercise patience, reason, and persuasion, but only as supplements to a life and practice demonstrating the high ideals of a profession devoted to the care of others. We must recognize that the medical profession in the United States represents to a great extent an island of relative freedom in a large world in which elsewhere it is more or less captive. We should remember Abraham Lincoln's aphorism that a nation cannot survive half slave and half free; or old John Donne's poem "No man is an island, entire of itself; every man is a piece of the continent, a part of the main."

It is not likely that the medical profession in America can long continue to remain unique in the world. It is more likely that the status of the medical profession throughout the world will tend to become more uniform. We should not, however, take the position that we are perfect as we are; but we should hold steadfastly to those standards which, after soul-searching, we think best. We may win. In any case, we must be sure that every

sound scheme for distributing the services and skills of the medical profession to all segments of the population, rich or poor, receives our support. We must recognize that there are problems before us that need solution. We must help find the solutions, and help to put them into operation. We believe that this can be done without significant changes in the present free enterprise system under which the medical profession in the United States operates. The battle is certainly on. We may lose, but we should by no means accept an attitude of defeatism. This country, in 1776, showed the world a road away from absolutism and towards democracy and freedom. It was a small and poor country at the time, but much of the world followed its example. The American medical profession can perhaps do the same in the years to come. In any case, win or lose, we can take comfort by following the admonition of Shakespeare's Polonius—"This above all: to thine own self be true; And it must follow, as the night the day, Thou canst not then be false to any man."

The reward of a battle well fought, even without victory, is not without its satisfactions.

Civilian Accidents Involving Atomic Material
Role of Public and Physician

In this day of the Atomic Age when the United States is maintaining a state of constant readiness, it is not unusual for nuclear weapons to be transported throughout the country. Transportation of these weapons may be by aircraft, truck, train and naval vessels. The weapons and their components are installed in special containers which are securely fastened to the transport vessels, and it is well known that a nuclear weapon cannot be set off without a series of specific positive actions. There is no absolute guard, however, against the possibility of accidents involving the units of transport. Hence it is believed advisable to give the physicians of Florida information relative to the dangers of an accident involving nuclear weapons, and to outline general steps which should be taken in the event of such an accident.

There are two components of a nuclear weapon which constitute the most probable hazards. These are (1) the high explosives and (2) plutonium. In addition, there are other materials involved in transport, particularly in aircraft and truck, which are of combustible nature, and which may add greatly to the existing hazards, especially if fire occurs. The high explosives are conventional in character, and are present in varying amounts up to many hundreds of pounds. These materials comprise the major hazard associated with accidents involving atomic weapons. The detonation, should it occur, may be a series of small explosions or one explosion of considerable magnitude. The danger here, aside from the scattering of metallic fragments, is that the radioactive material may become widespread. The material present in the unexploded bomb is plutonium. Plutonium may become dispersed as small particles as a result of the impact, or as a result of the detonation of high explosives, or as fumes if a fire occurs. So long as the plutonium remains outside the body, no harmful effects will occur. The greatest danger of entry of plutonium into the body is when it is suspended in the air, particularly in smoke, and deposited in the lungs or through cuts. Entry may occur through the oral cavity, but danger is slight, as the plutonium is in an insoluble form, and only a small amount will be absorbed.

Plutonium is an alpha emitter, and the alpha particles have a very short range and lack the ability to penetrate the unbroken skin. Conventional survey meters are of little use in detecting alpha radiation. Special teams trained for handling nuclear accidents are the only personnel capable of evaluating radiologic situations at the scene of an accident.

Should a physician be present at the time of an accident or be called to the scene of an accident possibly involving nuclear weapons, the following steps should be taken: (1) Be sure that the police department and the nearest military installation or Atomic Energy Commission office are notified at once. (2) Give immediate assistance to personnel, if possible, in an attempt to save lives. Otherwise, stay at least 1,500 feet away from the accident scene, and keep sightseers away at least a similar distance because of the danger of detonation of high explosives. (3) Stay

out of the smoke. If there is a fire, do not enter the smoke except to save lives. Approach from upwind, and uphill if possible. There may be caustic, toxic or minor radioactive hazards in the smoke. (4) Do not try to fight the fire if it is believed ammunition may be present. (5) Do not touch anything unnecessarily, and do not pocket or retain anything as souvenirs which may be found in the area. (6) Following the accident, and particularly if there has been associated fire, do not attempt to, or encourage any unauthorized personnel to, re-enter the area. See that all persons who may have been contaminated by the smoke, and those directly or indirectly involved in the accident, are monitored by members of the special Radiological Assistance Team.

W. DEAN STEWARD, M.D., *Chairman*
COMMITTEE ON CIVIL DEFENSE AND DISASTER

President Annis Carries the Torch For Florida Medicine

That the office of President of the Florida Medical Association requires a "considerable amount of durability" no one who follows the heavy travel and speaking schedule of President Jere W. Annis of Lakeland would doubt. Fast-moving, hard-working President Annis, now past the half way mark in his term of office, understandably advised the members of the Woman's Auxiliary to the Association at their Daytona Beach meeting on Oct. 22, 1958, that a prime requisite for this office is to be "not smart, but rugged." Month after month, his numerous speaking engagements carry the voice of Florida Medicine to various allied and other lay groups throughout the state and beyond as well as to members of the Association.

A few days before keeping this Daytona Beach engagement, he was addressing the New Port Richey Chamber of Commerce on "The Community Hospital," giving words of wisdom and competent advice out of personal experience on how to obtain a community hospital. After citing Lakeland's solution to the problem of securing an adequate hospital and reviewing all the data which must be accumulated, laid carefully on the table, analyzed and conscientiously and objectively examined, he counseled:

"Then, with an eye to future development; with a realization that you are establishing a responsibility for the community, as well as an asset; and that you are undertaking a serious, expensive, time-consuming job which is fraught with headaches, disappointments and disillusionments—then with a burning zeal to accomplish the impossible—then, and only then, can you set out as a group to achieve that which will many times seem impossible—which will eventually prove difficult and heartbreaking—and which will often make you regret the day you ever undertook it; but which, too, when all is said and done, will give you an honest and lasting pride; a real sense of worth while accomplishment, and an almost religious satisfaction of having labored hard and accomplished much for your neighbors and yourselves. This will make the struggle a crusade and it will heal all your wounds when you see, one day, a life that would have been lost without this institution, saved by it—then surely you shall have reaped your full reward . . . .

"The choice is yours and yours alone. Remember this, and be guided by it: Men do not fail—they only give up."

Hurrying from the Auxiliary meeting to San Francisco, Dr. Annis participated in the Thirty-First Scientific Session of the American Heart Association. Upon his return he addressed the Nursing Staff of Lakeland's Morrell Memorial Hospital on "Some Recent Advances in Cardiology," presenting a most informative and instructional kaleidoscopic review of the scientific material presented at that meeting.

The very next day he addressed the Florida Engineering Society, meeting in Lakeland, on the subject of the "History of Medicine and Professionalism." In a most enlightening and engaging fashion he set forth for the engineers American Medicine's noble concept of its calling and elucidated the goals of the profession.

It was with the doctors' wives at their annual Auxiliary meeting that Dr. Annis discussed their husbands' business, their Florida Medical Association, which is in the process of being renovated and streamlined this year. His words will be of interest to all members of the Association:

"First of all, this Florida Medical Association is but one component tile in the mosaic of American Medicine. It reflects — or it *should* reflect—accurately, the color, the feeling and the thinking of the doctors of Florida. It is so constituted that it can do this; and if it fails, it does so only because *your* husband and myself have



Dr. Annis

been derelict in our right and duty of individual expression and debate.

"Secondly, as a part—an integral part—of the face of American Medicine, it represents to the rest of the world certain basic philosophic principles, together with their interpretation and application. It takes its part in accepting the responsibility of our position and heritage in counseling and guiding American thought—especially in certain channels. This is the position of American Medicine — a position of great privilege, great trust, great honor and great responsibility; and it can be filled only by carefully considered, deliberative, cooperative effort on the part of the Nation's 200,000 doctors. This year these men of Medicine have signified to us by electing Dr. Louis Orr, of Orlando, to their highest office, that they are ready for Florida to provide leadership in this tremendous undertaking. Certainly Dr. Orr will more than adequately fulfill his obligations. We wish to be sure that the Florida Medical Association, under the spotlight of national scrutiny, performs as well.

"On a local and a national scale, this is an era of adjustment, of adaptation to modern times and problems. No longer is there time or room for the smug self-indulgence of which we have been guilty in the past. Here certainly is no place for inflexible rigidity of thought and action. The country and the world will consider with a justified lack of sympathy and respect any program or proposals born in prejudice, in selfishness, or in a lack of comprehension and understanding of our national problems and our national thought. This world of today will, as never before, however, listen critically to rationally expressed arguments and will carefully scrutinize data of proven experiment. It will likewise reject with equal celerity presentations consisting of pompous repetition of ideological principles which are based solely on tradition and precedent.

"New problems walk our global world. Let us at least be aware of them and alter our methods of attack and defense to meet them successfully. Failure to do so will assure us of the same fate that has befallen every army in history that failed to modernize its equipment and its tactics. Indeed, it seems probable to me that the very survival of our entire Western Civilization may well depend upon our ability to competently and impartially criticize ourselves and to profit by this criticism. To this end, we have attempted to modernize and reconstruct the machinery of the Florida Medical Association, and this proposed change will be presented to each County Association and to the House of Delegates for opinions, advice, amendments and final adoption in the form of a new Charter and By-Laws."

At this writing, Dr. Annis is attending the Twelfth Clinical Meeting of the American Medical Association in Minneapolis.

January Cover



Trephining in Ancient Peru

On the dry, sunswept Pacific coastline of the Paracas peninsula, a first-century Peruvian surgeon is pictured beginning a trephining operation, using knives of glass-hard obsidian, a crude plant narcotic, cotton, and bandages. Assistants immobilize the patient, and a priest seeks supernatural intervention through incantations and prayers as the slow and highly hazardous operation proceeds. (Courtesy of Parke, Davis & Company)

Dr. Orr Addresses Lawyers On A.M.A.-A.B.A. Rapport

A featured speaker at the Diamond Jubilee and Homecoming of Stetson University in DeLand on Nov. 15, 1958, was Dr. Louis M. Orr, of Orlando, President-Elect of the American Medical Association. Addressing the Stetson Lawyers Association, Dr. Orr chose as his subject "Physical and Civic Well-Being." At the outset he praised the improved understanding between the medical and legal professions as "the direct flowering of the seeds of harmony sown by the creation of the joint A.M.A.-A.B.A. committee in June of 1957." He declared that relations between lawyers and doctors have improved 100 per cent during the last year and a half and added that the American Medical Association desires nothing short of the highest rapport between physicians and attorneys.

"Although our two professions are structurally dissimilar," Dr. Orr continued, "there is a likeness in their goals. Physicians cure illness, prevent pain and heal wounds, which all lead toward the ultimate objective of the best possible physical health. Lawyers, on the other hand, cure ailments of society and prevent the social pain of crime by the administration of justice and the application of the laws. The impartial administering of justice, which has been called the 'vitamins of society,' helps improve the social and moral health of the community. Thus the professions are allied in the purpose of preserving the physical and civic health of our nation."

Believing that many lawyers have been honestly puzzled about the rancor felt against their profession by some doctors, Dr. Orr reviewed the doctor's position in the medicolegal field, comparing it to that of the small boy who fell in the water while fishing. After pulling him out, his father asked, "Son, how did you come to fall in the water?" The boy replied, "I didn't come to fall in the water—I came to fish." Many physicians argue that they did not study medicine to become entangled in medicolegal affairs. "Nevertheless, they, too, are 'in the water' and had better learn how to swim," advised Dr. Orr. "Swimming in this case means learning how to perform properly as a medical witness . . . assisting in the betterment of understanding between the medical and legal professions . . . and taking the necessary steps to stay out of court as defendants in professional liability actions. It is sad to realize that the average physician's attitude toward court appearances was summarized recently by a man who is both a doctor and a lawyer. He said in part:

"'To the physician, the courtroom means wasting valuable time to give a carefully restricted opinion, necessarily based on inadequate observation, for persons who cannot understand the details of the problem and who probably will not believe him anyway.'"

Dr. Orr pointed out that doctors who have been impressed by exaggerated tales of the stereotyped "typical" trial lawyer who humiliates, contradicts and then ridicules medical witnesses are surprised to find that most lawyers are human, with very normal emotions and attitudes, such as respect for a brother profession and a desire to regard doctors as partners in the joint task of impartially administering justice. He pictured physicians as strangers to situations which lawyers find commonplace and reminded lawyers of their obligation to acquaint doctors with courtroom tactics and the procedures likely to be used in the particular case so that they will be properly prepared and can testify with dignity and intelligence, without fear or doubt. Too, few doctors can spare the time court cases devour and become justly irritated when obliged to twiddle their thumbs in court for hours which should be spent in hospital and sick calls and keeping office appointments, for a doctor's most important concern is for his patient at all times."

"Our need for finding workable solutions to the medical testimony problem is evident when we realize that between 65 and 80 percent of all litigation in our courts today requires some type of medical reports or testimony," Dr. Orr declared. "And seven out of 10 personal injury cases are decided on medical rather than legal considerations." Noting that a recent study shows the vast majority of all professional liability claims and suits are not justly founded, Dr. Orr observed, "It is ironic that the very skill of modern doctors is one of the primary causes of malpractice claims. Medicine has advanced so rapidly that many patients expect perfect solutions to their medical problems. The public believes that very few ills are incurable, and in areas where cures are normally obtained, the doctor is sometimes blamed if the results are not entirely what the patients expect. . . .

"Doctors are as interested in the civic health of our nation as they are in its physical well-being. And I know lawyers share the desire of phy-

sicians to safeguard the health of America in all aspects. We are not two clashing opponents, but rather two groups of citizens, bearing different arms, but both battling together for our ideals. Let us understand and assist one another in this struggle. Our unity and harmony will inspire those we serve.

"Physical and civic health—upon these rest the welfare of humanity."

1958 Fall Fair Season Exhibit Round-up

"Mama! Come over here and see how babies are made from scratch!"

This remark, overheard at the Escambia County Medical Society's exhibit in the Pensacola Interstate Fair, is typical of the public reaction to the four successful county medical society exhibits presented during the 1958 fall fair season. This was the largest number of society-sponsored exhibits held to date in this annual fair season.

The Escambia exhibit, the first of the four projects, was held October 20-26. Featured was a return visit to Florida of the American Medical Association's unique exhibit entitled "Life Begins" which attracted wide public attention in previous appearances in Tampa, Orlando, Miami and Tallahassee. Members of the society on duty at the exhibit answered many questions from interested spectators. The Woman's Auxiliary to the Escambia County Medical Society was in charge of prefair arrangements. Mrs. Bernard M. Barrett, of Pensacola, is president of the group. Supervising the entire project was Dr. Constantine A. Asters, also of Pensacola, chairman of the society's exhibit committee.

The new American Medical Association exhibit entitled "Your Glands" was the focal point of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society's exhibit in the North Florida Fair held October 28-November 1. The Tallahassee showing marked the initial display of "Your Glands" in the state. The Woman's Auxiliary to the society assisted the physicians in staffing the exhibit, which was viewed by some 68,000 persons. Auxiliary chairman for the exhibit was Mrs. Robert N. Webster, of Tallahassee. The project was directed by Dr. Francis T. Holland, also of Tallahassee, chairman of the society's committee on public relations.

"Nutrition" was the theme of an exhibit presented by the Putnam County Medical Society in the Putnam County Fair held in Palatka November 10-15. This popular subject was illustrated by an American Medical Association exhibit which showed the required daily amounts and varieties of food necessary for adequate nourishment in various age groups. An added feature of the exhibit was a Future Nurses Club display sponsored by the Woman's Auxiliary to the Putnam County Medical Society. Dr. Lawrence G. Hebel, of Palatka, chairman of the society's committee on public relations, was in charge of the exhibit arrangements.



The Duval County Medical Society sponsored the exhibit "Life Begins" at the Greater Jacksonville Fair. Shown with the exhibit are (left to right) Drs. Irvine K. Furman, John H. Terry, Kenneth A. Morris, J. Ellis Lanier and Harry L. Collins Jr. All are from Jacksonville. For the North Florida Fair in Tallahassee, the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society selected the exhibit "Your Glands." Dr. Fred A. Butler, of Tallahassee, explains a point made by the exhibit to two young fair visitors, while Dr. Luther L. Pararo, also from Tallahassee, sits waiting his turn to answer questions.

The Greater Jacksonville Fair, held in the Gator Bowl November 13-22, was the scene of another Florida showing of the popular exhibit "Life Begins." The Duval County Medical Society's exhibit was seen by better than 100,000 interested persons. Society "Welcome Wagon" pamphlets and other literature were passed out by doctors to the throngs visiting the fair. In this, its first public exhibit project, the society was assisted by its Woman's Auxiliary under the leadership of Mrs. Joseph A. J. Farrington, of Jacksonville, president, and Mrs. John T. Stage, also of Jacksonville, chairman of the exhibit decorating committee. The over-all exhibit planning was directed by Dr. A. Sherrod Morrow, of Jacksonville, chairman of the Duval County Medical Society's committee on publicity and public relations.

Ophthalmology and Otolaryngology Midwinter Seminar Miami Beach, Feb. 16-21, 1959

The Florida Midwinter Seminar of Ophthalmology and Otolaryngology will convene on February 16 at the Americana Hotel in Miami Beach and continue through February 21. The lectures on Otolaryngology are scheduled for February 16, 17 and 18 and those on Ophthalmology for February 19, 20 and 21. All meetings will be held from 8:30 a.m. to 1:30 p.m. This thirteenth annual session will be presented in cooperation with the College of Medicine of the University of Florida and the University of Miami School of Medicine.

The usual midweek social features will consist of a cocktail party at 6:30 p.m. on Wednesday, February 18, at which all registrants and their wives will be guests, and an informal dinner for all registrants and their wives for which tickets must be obtained in advance.

Lecturers on Otolaryngology and their subjects are: Dr. John J. Conley, of New York, "The Significance of the Lump in the Neck," "Treatment of Cancer of the Ear and Temporal Bone," and "Treatment of Melanoma in the Head and Neck;" Dr. George T. Harrell, of Gainesville, "Medical Education and Changing Medical Practice," "The Use and Abuse of Antibiotics," and "Thyroid Function in Otolaryngology;" Dr. William C. Huffman, of Iowa City, Iowa, "Facial Lacerations," "The Deviated Nose," and "Otoplasty for the Protruding Auricle;" Dr. P. E. Ireland, of Toronto, Canada, "Nasal Discharge, Nasal Obstruction and Sinusitis," "The Importance of Noise Hazards to Our Specialty," and "The Common Sense Treatment of the Office Patient;" and Dr. Arthur L. Juers, of Louisville, Ky., "Tympanic Perforations - Marginal Eversion Method of Office Closure," "Tympanoplasty (Hearing Conservation Surgery for Chronic Ear Discharge),"and "Clinical Observations on Serous Otitis Media."

Ophthalmologists who will lecture and their subjects are: Dr. Frank D. Carroll, of New York, "Diseases of the Optic Nerve," "Optic Neuritis, Differential Diagnosis and Treatment," and "The Toxic Amblyopias;" Dr. Paul A. Chandler, of Boston, "Management of Angle Closure Glaucoma," "Management of Open Angle Glaucoma" and "Treatment of Secondary Glaucoma;" Dr. John W. Henderson, of Ann Arbor, Mich., "The Ocular Problems Associated with Carotid Cavernous Fistulas," "Ophthalmological Findings of Aneurysms of the Circle of Willis," and "The Problem of Progressive Thyroid Exophthalmos;" Dr. Edward W. D. Norton, of Miami, "Considerations in the Management of Aphakic Detachment," "Some External Ocular Manifestations of Systemic Disease," and "Clinical Manifestations of Lesions of Third Cranial Nerve"; and Dr. Harvey E. Thorpe, of Pittsburgh, "The Managemen of Intraocular Foreign Bodies," "Recent Advance in Gonioscopy," and "Alpha Chymotrypsin Zonulysis in Cataract Surgery."

Legislative Department Director Added To Staff

The Florida Medical Association announces the employment of Alvin D. James as Director of the newly created Legislative Department. Prior to joining the staff of the Association, Mr. James was employed by the Florida State Board of Health. He served in the capacity of Hospital Consultant, and his duties were concerned with state level supervision of the state aid program: Hospital Service for the Indigent.

A native of North Carolina, he received his pre-college education under the Mecklenburg County School System and Wingate Junior College. Entering the armed forces as an enlisted man in early 1945, he served four years in the amphibious forces of the United States Navy. Fur-

ther military service includes education in the Air Force Reserve Officer Training Corps while attending the University of North Carolina.

Upon discharge from active military service, Mr. James attended the University of North Carolina, where he was graduated in 1954 with the degree of Bachelor of Science in Business Administration. Postgraduate education in the field of hospital administration was received at Memorial Hospital, Charlotte, N. C. Upon completion of the two year course, he was awarded the certificate of Hospital Administrator.

Previous engagements include serving as an administrative assistant at the North Carolina Memorial Hospital, Chapel Hill, N. C., and as administrative resident at Memorial Hospital, Charlotte, N. C. He is presently serving as the administrative assistant to the Citizens Medical Committee on Health, appointed by Governor LeRoy Collins in April 1958.

Cardiovascular Diseases Annual Seminar Jacksonville, Feb. 19-21, 1959

The Sixth Annual Seminar on Cardiovascular Diseases will be held on Thursday, Friday and Saturday, February 19-21, 1959, at the Prudential Auditorium in Jacksonville. This course is sponsored by the Northeast Florida Heart Association in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida. The Seminar has been accepted for credit by the American Academy of General Practice.

The speakers for the course are Dr. Samuel A. Levine, Clinical Professor of Medicine, Harvard Medical School; Dr. Irving S. Wright, Professor of Medicine, Cornell University Medical College; Dr. A. G. Morrow, Assistant Professor of Surgery, Johns Hopkins University School of Medicine, and Chief, Clinic of Surgery, National Heart Institute; Dr. Victor A. McKusick, Associate Professor of Medicine, Johns Hopkins University School of Medicine; Dr. Max Michael Jr., Clinical Professor of Medicine, College of Medicine, University of Florida, and Executive Director, Jacksonville Hospitals Educational Program, Inc.; Dr. William J. Taylor, Assistant Professor of Medicine, College of Medicine, University of Florida; and Dr. Myron W. Wheat Jr., Assistant Professor of Surgery, College of Medicine, University of Florida.

This course will include recent developments in the diagnosis and treatment of Cardiovascular Diseases. The formal lectures will be correlated with panel discussions and question periods in which the entire staff will participate.

Information may be obtained from Dr. Daniel R. Usdin, Chairman, Cardiovascular Seminar, Northeast Florida Heart Association, 1628 San Marco Boulevard, Suite 7, Jacksonville 7.

Central Florida Medical Meeting Orlando, March 12, 1959

The Fifth Annual Central Florida Medical Meeting, sponsored by the Orange County Medical Society, will be held on Thursday, March 12, 1959, at the San Juan Hotel in Orlando.

Participating in the program will be outstanding speakers in various fields. Dr. Russell J. Blattner, Professor of Pediatrics, Baylor University Medical School, Houston, Texas, will discuss pediatric problems. Dr. William Parson, Professor and Head of the Department of Internal Medicine, University of Virginia School of Medicine and Hospital, Charlottesville, Va., will speak on "Obesity." Dr. James Elliott Scarborough Jr., Director of the Winship Memorial Cancer Clinic at Emory University Hospital, Atlanta, Ga., will discuss cancer. A speaker from the Armed Forces Institute of Pathology will discuss the "Medical Importance of Fluorescent Antibody Technique." Dr. Robert J. Boucek, Director of Cardiovascular Research at Howard Hughes Research Center, Miami, will speak on "Arteriosclerosis Research."

Following the formal papers, the speakers will meet with small groups of interested physicians who may ask questions regarding the papers or regarding problems that they may have in their own practice.

Registration for the meeting will begin at 8 a.m. Pharmaceutical organizations will have displays on the mezzanine floor again this year. A cocktail party and banquet will terminate the program in the evening.

All physicians throughout the state are cordially invited to be present and bring their wives. Activities for the wives are planned by the Woman's Auxiliary to the Orange County Medical Society with Mrs. Truett Frazier serving as chairman.

Further information may be obtained by contacting the Chairman of Arrangements, Dr. An-

drew W. Townes Jr., or the Orange County Medical Society Executive Office, 21 East Copeland Drive, Orlando.

Foreign Medical Graduates' Examination Results Announced

Results of the first worldwide American Medical Qualification Examination held Sept. 23 in 30 United States examination centers and 30 foreign centers were announced recently by Dr. Dean F. Smiley, Executive Director, Educational Council for Foreign Medical Graduates. The foreign centers were established in Latin America, the Far East, the Middle East and Europe.

Of the 844 foreign-trained physicians taking the examination, 418 passed and will receive the ECFMG Certificate. According to the council, these physicians are certified as possessing medical knowledge reasonably equivalent to that expected of graduates of approved American and Canadian medical schools and as having satisfactory facility in the English language. There were 226 candidates who came sufficiently close to passing, in spite of language difficulties, to earn temporary certificates which will qualify them to study not more than two years as interns or residents in United States hospitals approved for internship or residency training.

Those foreign-trained physicians who pass the examination and enter the United States on exchange visitor visas may participate in the National Intern Matching Program or apply directly to a hospital for an internship or residency, Dr. Smiley explained. He also pointed out that graduates entering the United States on immigrant visas may be admitted to licensing examinations in at least 16 states. He added that a number of the medical specialty boards in the United States will accept certification by the ECFMG as satisfying their requirements that candidates for their certifying examinations are graduates of approved schools of medicine.

Located in Evanston, Ill., the Council for Foreign Medical Graduates was established in 1957 as a means of evaluating the education of foreign medical graduates wishing to take advanced training or obtain licenses in the United States. On March 25 of last year the council administered the first examination of this type in 17 stations in the United States. Fifty-one per cent of the 300 applicants tested passed this initial test.

The American Medical Qualifications Examinations for 1959 are scheduled for February 17 and September 22. To be admitted to these examinations the candidate is required to present, three months in advance, an application and credentials confirming that he has had 18 years or more of formal education at least four of which have been in a recognized school of medicine.

Other sponsoring organizations of the examinations are the Association of American Medical Colleges, the American Hospital Association, the American Medical Association, and the Federation of State Medical Boards of the United States.

OTHERS ARE SAYING

Editorial

Now that Congress has reconvened the medical profession is once again wondering if there will be any change in the Social Security Bill and if the Jenkins-Keogh Bill will be passed. With inflation ever on the rise, insurance alone becomes inadequate provision for the future due to depreciation of the dollar. At the present time, physicians are the only group not included in Social Security. Members of Congress have told us repeatedly that they would never pass Social Security for doctors on a voluntary basis. It would have to be compulsory or not at all.

A recent issue of Medical Economics has made an analysis of Social Security and gave their opinion in an unbiased fashion. They have avoided any aspects that would be considered under the moral or philosophical aspects of the Bill. It is very difficult to compare Social Security insurance to insurance offered by private companies, as no private company offers exactly the same type of policy that Social Security offers. A reasonable comparison, however, can be made. If you are forty years of age a policy comparable to Social Security would cost you an annual premium of $777.59 compared to $229.50 if averaged over the working years to the age of 68. The total premium for private insurance would amount to over $21,000 compared, approximately, to $6,500 for Social Security over the same period of time. This is based on the Social Security Act as it now stands, which sets the tax for self employed persons at 3⅜%, at the present time, and will advance to 6⅜% in the 1970-74 period. Of course, the rate may be amended and increased,

but usually when Congress raises the rates the benefits are also broadened at the same time.

There are several disadvantages in Social Security in that the provisions are rigid and allow for no variation, whereas many individual variations can be made in private insurance. For the average man with several children, though, he can fit into the rigid form of Social Security without much difficulty. He must continue practicing at least a year and a half after Social Security has started before he can become eligible for benefits. Another disadvantage is that it limits the amount that a person receiving benefits is allowed to earn. If your wife started having an income after your death, over $1,200 yearly, and she were less than 72 years of age, she would lose some Social Security benefits. There are some economic disadvantages to Social Security, but the advantages seem to me to outweigh them. Self employed dentists and lawyers have decided to overlook the disadvantages and have become covered under the Social Security system.

I have heard many talks and have read countless articles concerning the pros and cons of Social Security versus private insurance, and as always, they become quite technical. Usually the person opposing Social Security ends up by bringing up the philisophical aspects of the situation and states that if the medical profession accepts this form of socialism, we therefore, cannot oppose socialism in any other form. To me this seems somewhat ridiculous. Partial socialism is a part of the American system today and the physicians are not going to alter it in the slightest. I think that we have all the disadvantages by not being under Social Security and none of the advantages. If Social Security is broadened so that the benefits exceed its income it may be necessary for Congress to take some of the tax money that it paid in income tax to help support the Social Security Fund. I do not think that we, as physicians, will be given a special tax break because we are not included in Social Security Fund and receive no benefit from it. I think we will have to pay for it like everyone else and do not derive any benefits from it.

Whatever your opinion is concerning Social Security, now is the time to sxpress it. Congress is in session and you should write to your Congressman and state your opinion as to whether you think doctors should be included under Social Security or not. Congress has many times intimated that they would never approve the Jenkins-Keogh Bill until we become a part of Social Security. I, personally, think we should abandon our outmoded opposition to Social Security and ask to be included.

Richard L. Foster, M.D.
The Record
Broward County Medical Association
March, 1958.

STATE BOARD OF HEALTH

Deaths From Penicillin Reactions

Allergic manifestations to penicillin are being reported much more frequently as the population is becoming more exposed to injections. A report in the Journal of the American Medical Association in 1956 linked this increased incidence of allergy to penicillin with administration of repeated courses of this antibiotic. It was found that first injections produced allergic manifestations in only 0.8 per cent of the persons injected. The reactions occurred in 1.6 per cent with the second injection, and in 3.6 per cent with the third injection. It has been estimated that 5 per cent of the "non-allergics" have some reaction to penicillin, and that untoward reactions develop in as high as 15 per cent of the "allergic" subjects.

During 1953 and 1954, as reported in the Annals of Allergy of 1955, a group of fatal and near fatal (anaphylactoid) reactions was recorded. One hundred forty-nine of the cases were reported in the literature, 67 of which were fatal, and in all but one case the penicillin was injected parenterally.

As reported in Antibiotic Medicine in 1955, there is, according to Brown, one chance in six of an anaphylactoid reaction developing when the patient is known to be allergic to substances other than penicillin, and the probability grows greater with each successive reaction to the antibiotic.

The majority of deaths follow the second to the sixth injection, and rarely occur after the first injection. The tendency of patients to exhibit an allergic or anaphylactoid reaction to penicillin cannot be accurately predicted prior to injection.

These facts are forcefully brought to the front by recent newspaper stories.

Studies from the death certificates in the Bureau of Vital Statistics of the Florida State Board of Health show that through the month of October 1958 five deaths were reported as being caused by anaphylactic reactions to penicillin.

Whether others occurred that were not recorded, of course, cannot be ascertained, and the number of severe reactions, both urticarial and anaphylactoid, that occurred which have not resulted in death cannot be determned. It behooves all physicians administering penicillin to recognize the dangers that may accompany the indiscriminate use of this most valuable antibiotic, particularly when administered in conditions in which it can be expected to accomplish little good, yet may sensitize patients so that they may not be able to take the drug when it is really needed.

BLUE SHIELD

To understand what is happening today, it is usually necessary to recall what happened yesterday. Dr. Russell B. Carson, President of Florida's Blue Shield Plan, explains that "Blue Shield was born of two parents—economic necessity and self preservation:"

Economic necessity of the patient, who needed medical care, wanted to pay for it himself and to the doctor of his own choice.

Self preservation for the doctor, from the bankruptcy of uncollectible bills and from domination by the welfare state.

Dr. Carson, addressing the 1958 National Blue Shield Professional Relations Conference, compared Blue Shield to a savings bank, in which the patient places regular deposits against the day when he needs money to pay for medical care.

From the doctor's viewpoint, "this savings bank became an extension of our own front offices because it was maintained by our own board of trustees. We do our own collecting and disbursing without deduction of a profit and without interference from any third party telling us how, when, or to whom the disbursement should be made. We doctors had, or should have had,. . . . control of these savings banks."

If we doctors are to benefit from Blue Shield, we must take an active, responsible interest in our Plans. Also, if we want our patients to continue making their deposits in the Blue Shield Bank, then we must demonstrate, day after day, that both Blue Shield and its sponsoring physicians are serving, first and foremost, the welfare of our patients and the public.

The role of the doctor, says Dr. Carson, "must be that he once again become an integral, interested, cooperating part of the idea and ideals of the Plan."

Economic necessity for the patient and self preservation for the doctor are both spotlighted again by the temper and tendencies of the recently elected Congress. When it goes into session this month, a swifter, less inhibited attack on medicoeconomic issues will be inevitable. Organized medicine's attack on these problems must be equally as swift and uninhibited. Blue Shield stands ready to continue, with a unified profession, to serve best the needs of both the public and the physician.

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SEARLE

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was elected as one of 12 directors of the Joint Council for the Health Care of the Aged at an incorporation meeting held late in October. Dr. Orr is vice-chairman of the Joint Council.

Among the group of Florida physicians attending the recent annual meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago were Drs. Thomas S. Edwards, Millard F. Jones, William J. Knauer Sr., William J. Knauer Jr., Shaler Richardson, G. Dekle Taylor and Louis A. Wilensky, all of Jacksonville.

Dr. Chas. McC. Gray of Tampa has been elected president of the Florida West Coast Radiological Society which was organized the middle of October at a meeting in Tampa. The group embodies the 32 radiologists from the Tampa, St. Petersburg, Lakeland, Clearwater, Sarasota and Ft. Myers area. Dr. Thomas W. Dorr of Tampa was elected vice president, and Dr. Joseph C. Rush of St. Petersburg, secretary-treasurer.

The organizational meeting was preceded by a dinner and followed by a scientific program moderated by Dr. Gray. Meetings will be held the third week of October, January, April and July.

Dr. James N. Patterson of Tampa was a member of the panel which discussed "The Coagulation of Blood" at the October meeting of the American Society of Clinical Pathologists held at Chicago. For his phase of the subject, Dr. Patterson discussed "Plasma and Serum Prothrombin Times." While in Chicago, Dr. Patterson served as one of the officials administering examinations of the American Board of Pathology at Northwestern University Medical School, and also attended the meeting of the College of American Pathologists held conjointly with the meeting of the American Society of Clinical Pathologists.

Dr. DeWitt C. Daughtry of Miami was elected 2nd vice president of the Southern Chapter

(Continued on page 814)

atlanta graduate medical assembly

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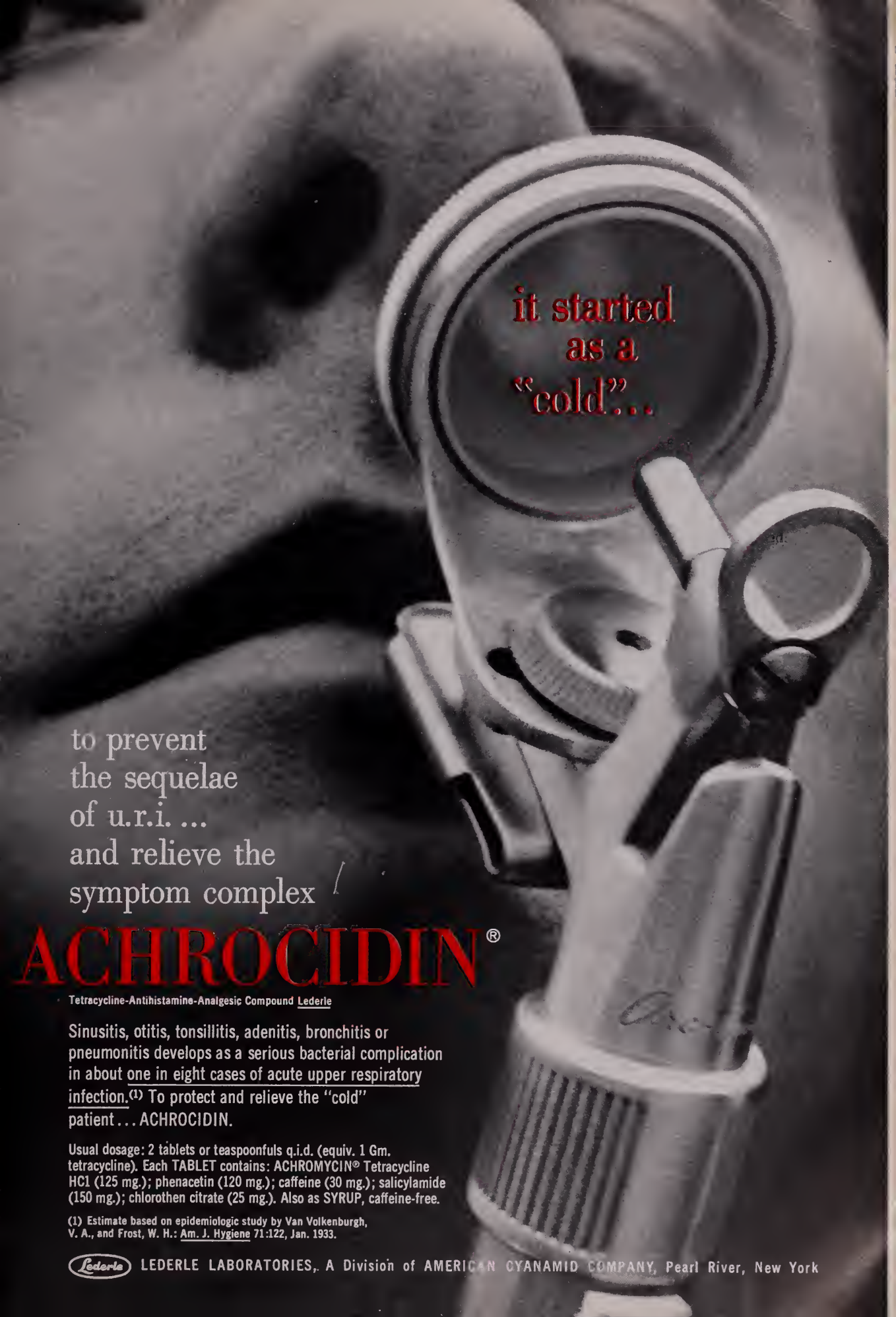
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Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

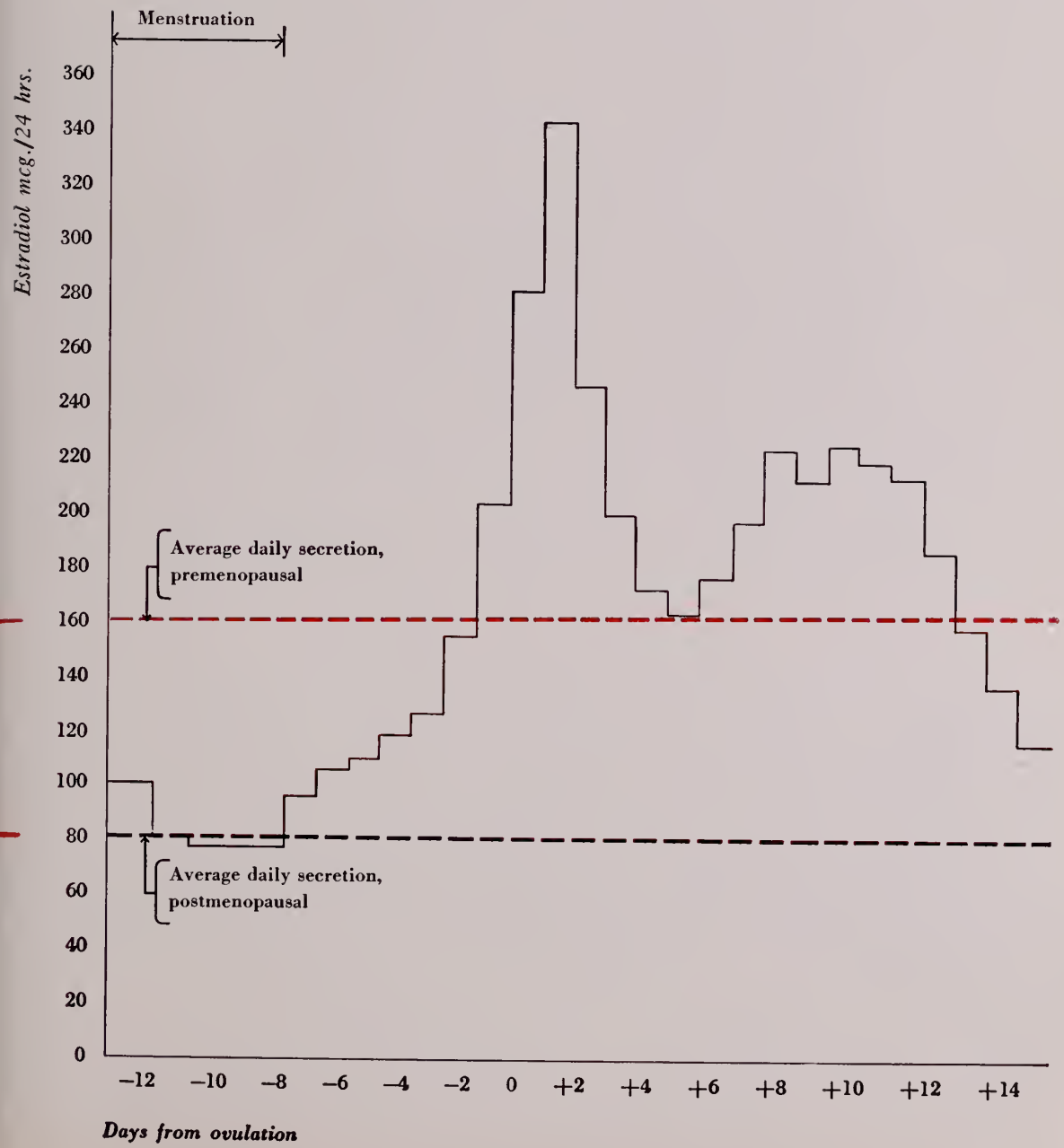
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

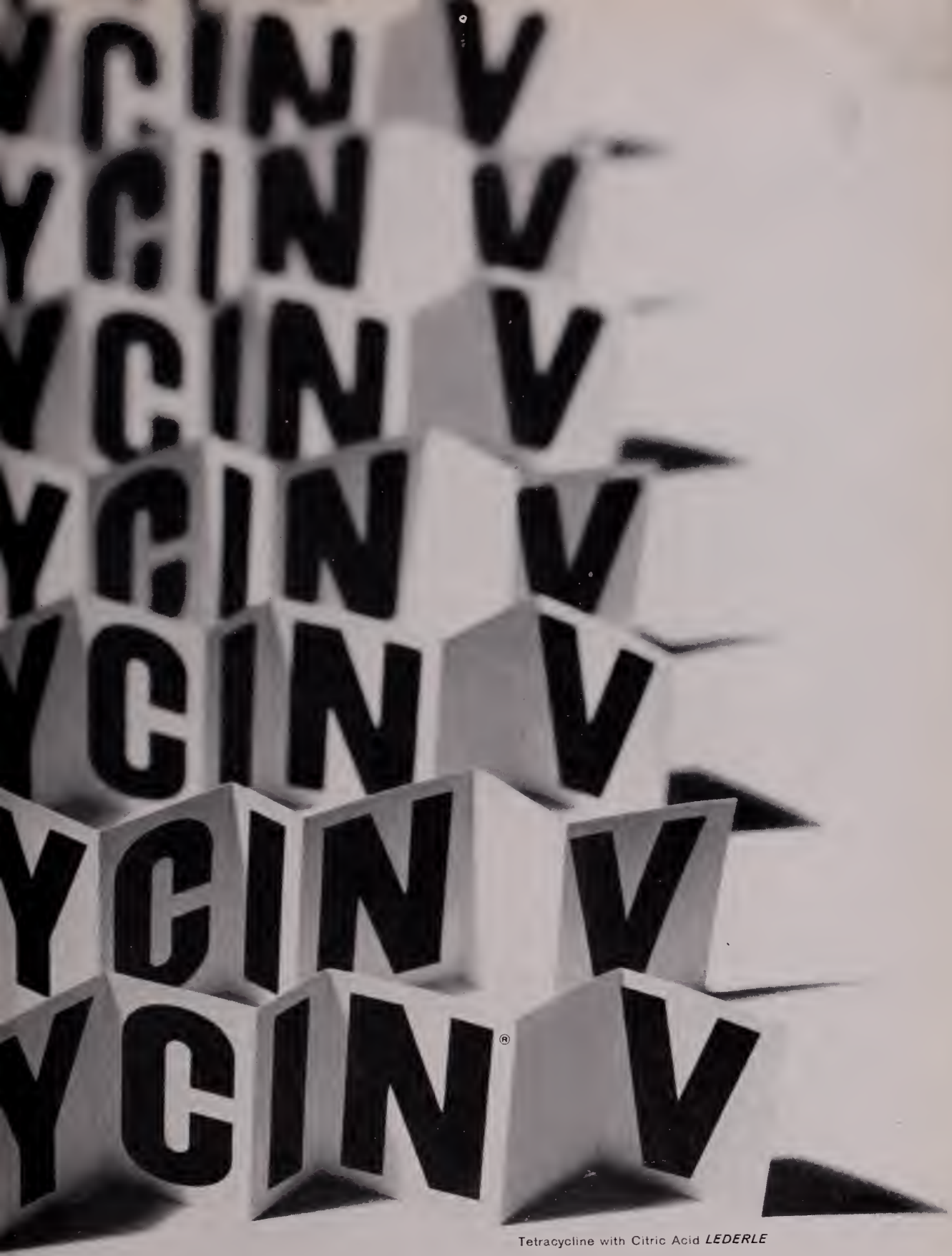
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Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)




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(Continued from page 808)

of the American College of Chest Physicians during the 15th annual meeting held early in November at New Orleans.

Dr. J. Brown Farrior of Tampa has received the Second Award of the American Academy of Ophthalmology and Otolaryngology for his work on the plastic reconstruction of the ear drum. The presentation took place at the annual meeting of the Academy held at Chicago. The First Award went to the University of California for work on cancer of the larynx, and the Third Award to Mount Sinai Hospital in New York for investigation into the causes of deafness.

Dr. Louis J. Polskin of Lakeland presented an address "Have Science—Will Travel" to the student body of the Kathleen High School, Kathleen, the latter part of November.

Dr. Robert J. Grayson of Miami Beach has been elected president of the newly organized American Association of Poison Control Centers. As Clinical Assistant Professor of Pediatrics at the University of Miami School of Medicine and with the cooperation of the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society, Dr. Grayson has been a pioneer in the establishment of poison control centers in Florida.

The College of Medicine, University of Florida, Gainesville, has been granted an additional $10,000 by the William G. and Marie Selby Foundation for long and short term loans by medical students. Dr. George T. Harrell, Dean of the College, has also announced that the W. K. Kellogg Foundation had granted the College $15,000 to provide a fund for long term medical student loans.

A grant of $26,910 from the National Institute of Arthritis and Metabolic Diseases has been announced by Dr. Edward R. Woodward, head of the Department of Surgery at the College of Medicine, University of Florida. The funds are to finance a study on the neural and neurohumoral mechanisms influencing gastric secretion and motility under the direction of Dr. Woodward.

Drs. James R. Sory of West Palm Beach, Herbert J. Simon of Hollywood and James F. Rob-

Announcing The Twenty-Second Annual Meeting
of
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Conference Headquarters — Roosevelt Hotel
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Otto H. Janton, M.D., Philadelphia, Penna.
Cardiology
Carl T. Nelson, M.D., New York, N. Y.
Dermatology
Clifford J. Barborka, M.D., Chicago, Ill.
Gastroenterology
Malcom E. Phelps, M.D., El Reno, Okla.
General Practice
Keith P. Russell, M.D., Los Angeles, Calif.
Gynecology
William Dameshek, M.D., Boston, Mass.
Internal Medicine
Howard P. Rome, M.D., Rochester, Minn.
Neuropsychiatry
R. Gordon Douglas, M.D., New York, N. Y.
Obstetrics
Maynard C. Wheeler, M.D., New York, N. Y.
Ophthalmology
Lenox D. Baker, M.D., Durham, N. C.
Orthopedic Surgery
Ben H. Senturia, M.D., St. Louis, Mo.
Otolaryngology
Francis Bayless, M.D., Cleveland, Ohio
Pathology
Lee F. Hill, M.D., Des Moines, Iowa
Pediatrics
Roy R. Greening, M.D., Philadelphia, Penna.
Radiology
John M. Dorsey, M.D., Evanston, Ill.
Surgery
F. Henry Ellis Jr., M.D., Rochester, Minn.
Surgery
Fred K. Garvey, M.D., Winston-Salem, N. C.
Urology

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures and technical exhibits.
(All-inclusive registration fee — $20.00)

THE CLINICAL TOUR TO MEXICO CITY, CUERNAVACA, TAXCO, ACAPULCO AND SAN JOSE PURUA

Leaving March 6 from New Orleans and returning March 21, 1959

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Until the discovery of DECADRON* by MERCK SHARP & DOHME, when your diabetic patients were also in need of corticosteroid treatment, you were often faced with a difficult therapeutic dilemma. Diabetes mellitus was a recognized contraindication to the use of corticosteroids, since they not only aggravated the existing diabetic symptoms, but often precipitated latent diabetes.

NOW EVEN many diabetic patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

DECADRON—the new and most potent of all anti-inflammatory corticosteroids—**is** remarkable for its **virtual absence of diabetogenic effect** in therapeutic doses.



Decadron*

DEXAMETHASONE

to treat more patients more effectively

In clinical trials with some 1,500 patients glycosuria was noted in only two, transitory glycosuria in another two, and flattening of the glucose tolerance curve in one. There were no instances of aggravation of existing diabetes, no increase in insulin requirements. Patients whose diabetes was severely aggravated on prednisolone showed good tolerance when transferred to DECADRON.

MORE patients can be treated with DECADRON than with other corticosteroids, because in addition to being practically free of diabetogenic activity, therapy with DECADRON is also practically free of sodium retention, potassium depletion, hypertension, edema and psychic disturbances. Cushingoid effects are fewer and milder. DECADRON has not caused any new or "peculiar" reactions, and has produced neither euphoria nor depression, but helps restore a "natural" sense of well-being.

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MSD MERCK SHARP & DOHME
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ertson of New Smyrna Beach were among the group of Florida physicians attending the recent meeting of the American College of Surgeons held at Chicago.

Dr. Joseph M. Bistowish Jr. of Tallahassee has been re-elected secretary-treasurer of the American Association of Public Health Physicians. He has also been appointed to the executive committee of the Southern Branch of the American Public Health Association which he served last year as president.

Dr. Samuel Gertman of Miami, director of the Institute of Gerontology at the University of Miami, presented a paper at the recent meeting of the Gerontological Society held in Philadelphia.

Dr. Wilson T. Sowder of Jacksonville, State Health Officer, has been elected vice president of the Association of State and Territorial Health Officers.

Dr. Stephen C. Wright of Miami has been appointed a member of the Florida Children's Commission by Governor LeRoy Collins.

Dr. Aubrey Y. Covington of Starke has been elected president of the Florida Public Health Association.

Dr. H. Milton Rogers of St. Petersburg, chairman of the Suncoast Heart Association Research Committee, and Dr. Claude G. Hooten Jr. of Clearwater, a member of the Association's board of directors, were among the Florida delegates at the annual meeting of the American Heart Association held at San Francisco.

Dr. Fred E. Manulis of Palm Beach has been elected a governor of the American College of Gastroenterology.

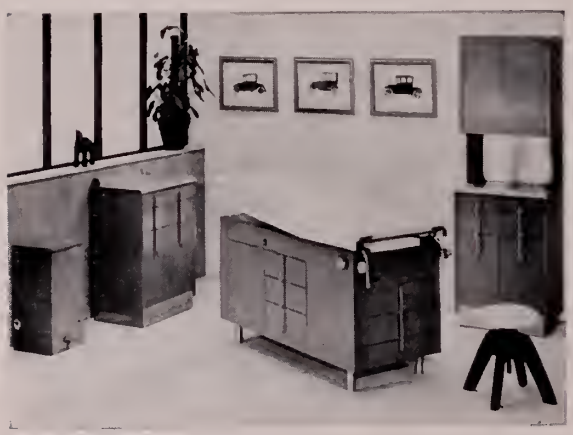
Dr. Thomas H. Bates of Lake City was guest speaker at a recent meeting of the Newcomers Club of that city. He also explained the film "Time and Two Women" presented as a part of the program.

Dr. Homer L. Pearson Jr. of Miami, secretary of the Florida State Board of Medical Examiners, was one of the principal speakers on the program

(Continued on page 827)

The distinctive PREMIERE suite

By Hamilton



Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere—and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basis and pull-out step are included.

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and open stuffed noses orally

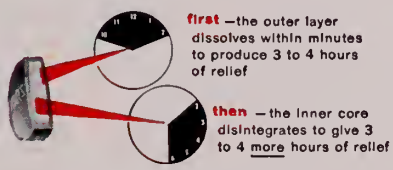
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each TRIAMINIC *Tablet provides:*

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
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One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®

(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia – plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem – and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases – "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children – "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults – "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.

2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.

3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin–Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.

4. J. A. M. A., 167:1584, July 26, 1958.

5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.

6. Billow, F. J., et al., Clinical Observations on Ristocetin–A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.

7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.

8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.

9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.

10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

FOR THE SLOW-TO-GROW CHILD B-VITAMIN SUPPORT...PLUS THE PROTEIN-POTENTIATING ACTION OF L-LYSINE..PLUS THE EXCEPTIONALLY WELL-TOLERATED HEMATINIC PERFORMANCE OF FERRIC PYRO-PHOSPHATE...AND THE IRON AND B_{12} ENHANCING ACTION OF SORBITOL IN DELICIOUS CHERRY FLAVORED

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BUILDS IRON RESERVES

BOOSTS APPETITE

PROMOTES GROWTH

Each daily teaspoonful dose (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	7.75%

Bottles of 4 and 16 fl. oz.

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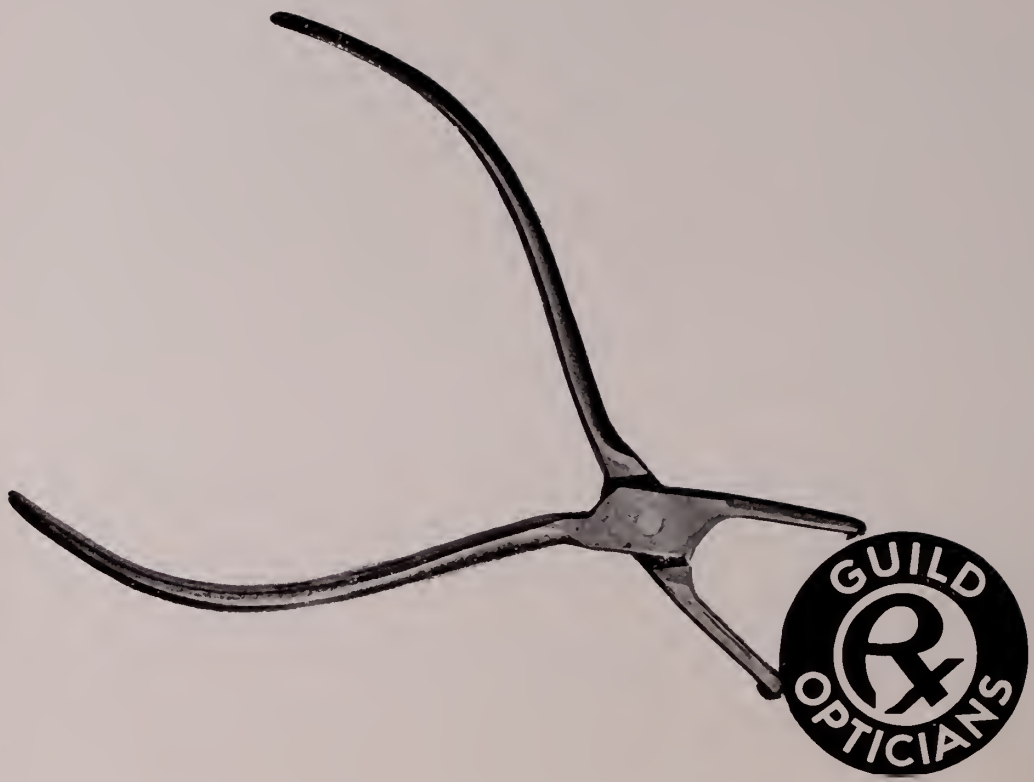
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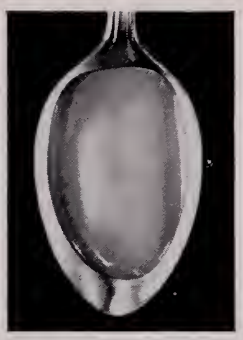
D 27



fitting that's proper

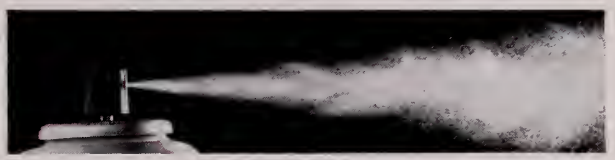
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in a form  to fit

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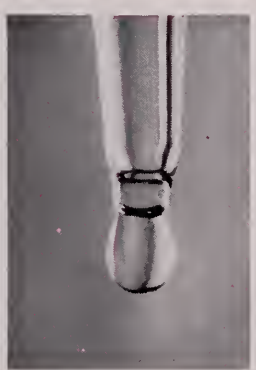
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ACHROMYCIN: Capsules • Ear Solution 0.5% • Intramuscular • Intravenous • Nasal Suspension with Hydrocortisone and Phenylpherine Ointment 3% • Ointment 3% with Hydrocortisone 2% • Ophthalmic Oil Suspension 1% • Ophthalmic Ointment 1% • Ophthalmic Ointment 1% with Hydrocortisone 1.5% • Ophthalmic Powder (Sterilized) • Oral Suspension • Pediatric Drops • PHARYNGETS® TROCHES Soluble Tablets • SPERSOIDS® Dispersible Powder • Surgical Powder (Sterilized) • Syrup • Tablets • Topical Spray • Troches

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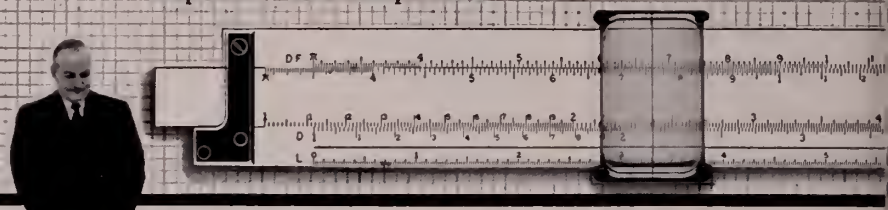
PRONOUNCED TAY-O

℞ Tao

(triacetyloleandomycin)

Capsules / Oral Suspension

* designed for superior control of common Gram-positiv infections

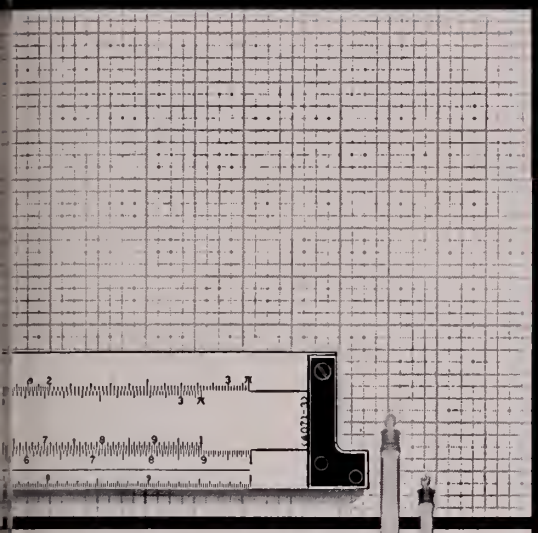




in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	558	448	80	30
Respiratory infections	258	208	31	19
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	–	6
Otitis media	31	29	2	–
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	230	191	38	1
Infected wounds, incisions and lacerations	41	33	8	–
Abscesses	51	43	8	–
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	–
Pyoderma	19	19	–	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	–
Genitourinary infections	28	19	3	6
Acute pyelitis and cystitis	10	8	2	–
Urethritis with gonorrhea or cystitis	8	8	–	–
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

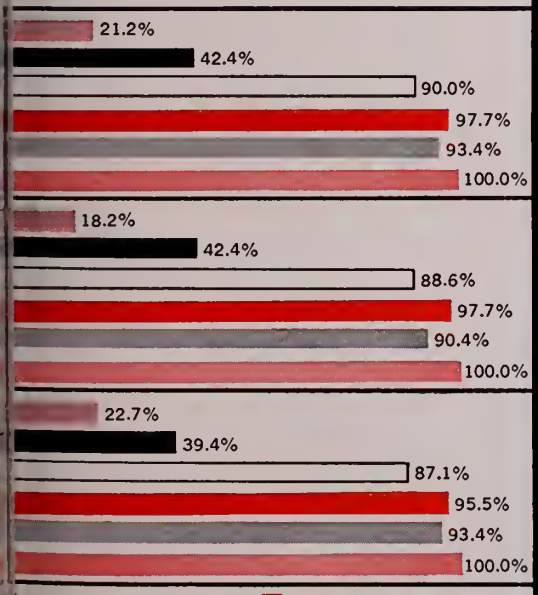


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(er 90% effective
;gainst resistant staph

MPARATIVE TESTS BY THREE METHODS
SC, TUBE DILUTION, CYLINDER PLATE)
130 STAPHYLOCOCCI[9]



rcentage of organisms inhibited by the range of
ncentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

Tao dosage forms—
for specific clinical situations

Tao Pediatric Drops

For children—flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg. of TAO) and 10 drops (approx. 25 mg. of TAO). 10 cc. bottle.

Tao-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

Taomid* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

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A green salad topped generously with shoestrings of meat and cheese carries its weight in protein. Cottage cheese for extra protein is especially tasty in a salad or as a spread on dark bread. An egg white whipped into fruit juice makes a frothy flip—and fruit and cheese for dessert give a big protein boost. For variety's sake a frosty glass of beer* adds zest to any meal as well as protein to the diet.

*Protein 0.8 Gm.; Calories 104/8 oz. glass (Averoge of American Beers)

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Beer—America's Beverage of Moderation

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(Continued from page 816)

of the 71st annual meeting of the American Institute of Certified Public Accountants held at Detroit.

Dr. William M. Bevis of Lakeland has been presented a certificate of merit by the University of Tennessee in recognition of services rendered to his community during the 50 years he has been a doctor of medicine.

Dr. Milton Segal of St. Augustine attended the recent meeting of the American Roentgen Ray Society held at Washington, D. C.

Dr. Mary C. Patras of Miami has been honored as a "Woman of Achievement" by the Business and Professional Women's Clubs of Dade County.

Dr. L. Roland Young of Daytona Beach attended the Southern Medical Association meeting in New Orleans early in November and while in Louisiana visited various hospitals and clinics.

Dr. William M. C. Wilhoit of Pensacola has been re-elected president of the Florida Association for Mental Health, and Dr. James A. Poyner of Panama City has been appointed a member of the Association's Board of Directors.

Dr. Sullivan G. Bedell of Jacksonville, chairman of the Committee on Mental Health, Florida Medical Association, and Dr. William M. C. Wilhoit of Pensacola, a member of the Committee, attended a conference of Mental Health Chairmen of State Medical Associations held in Chicago late in November. Among the principal speakers were Dr. Gunnar Gundersen, President of the American Medical Association, and Dr. Jonas Salk.

Florida physicians attending the Twelfth Clinical Meeting of the American Medical Association held in Minneapolis early in December included Drs. Louis M. Orr and Miles W. Thomley of Orlando; Jere W. Annis of Lakeland; Reuben B. Chrisman Jr. of Coral Gables; Burns A. Dobbins Jr. and Russell B. Carson of Fort Lauderdale; Francis T. Holland of Tallahassee; Homer L. Pearson Jr. and Walter W. Sackett Jr. of Miami; Paul V. Reinartz of Jacksonville, and Ernest A. Reiner of Tampa.



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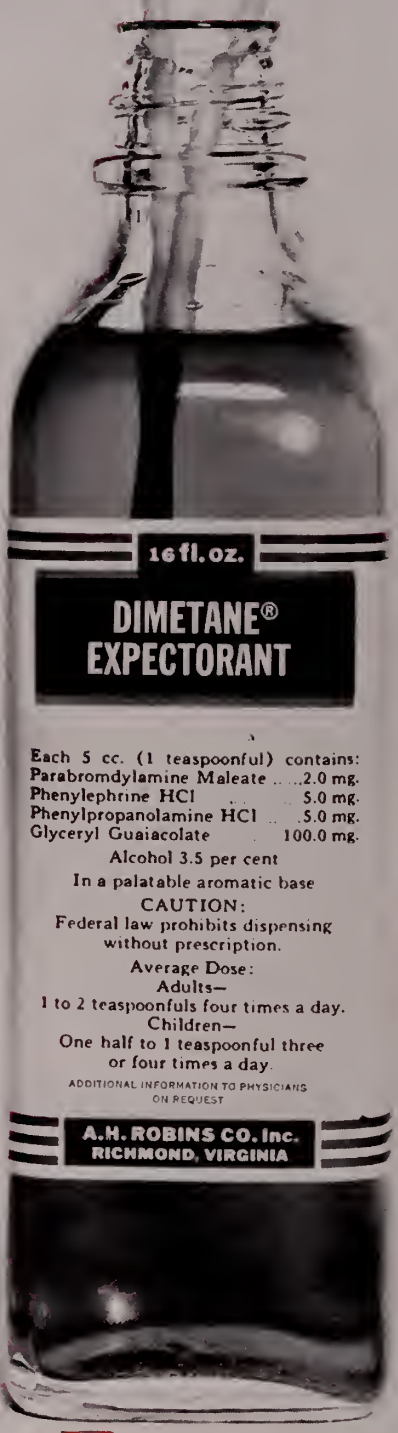
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THE FESLER COMPANY, INC. • 375 Fairfield Ave., Stamford, Conn.

new for cough



tastes good

the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceryl Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.

works better

combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

Dimetane® Expectorant
Dimetane® Expectorant-DC

Robins

(WITH DIHYDROCODEINONE BITARTRATE 1.8 MG./5CC.)

COMPONENT SOCIETY NOTES

St. Lucie-Okeechobee-Martin

Dr. Alvin E. Murphy of Palm Beach, councilor for the Seventh Medical District of the Florida Medical Association, was principal speaker at the October meeting of the St. Lucie-Okeechobee-Martin County Medical Society. He discussed the organization of the Association and its aims.

Orange

Safeguards against explosions of anesthetic agents in operating and delivery rooms were demonstrated by Dr. George J. Thomas of Pittsburgh at the November meeting of the Orange County Medical Society held in the Educational Building of the Orange Memorial Hospital.

Dr. Thomas is Chairman of the Section on Anesthesiology at the University of Pittsburgh School of Medicine and Director of the Departments of Anesthesiology at St. Francis General and Medical Center Hospitals in Pittsburgh. He has been active in research on the prevention of fires and explosions with flammable anesthetic

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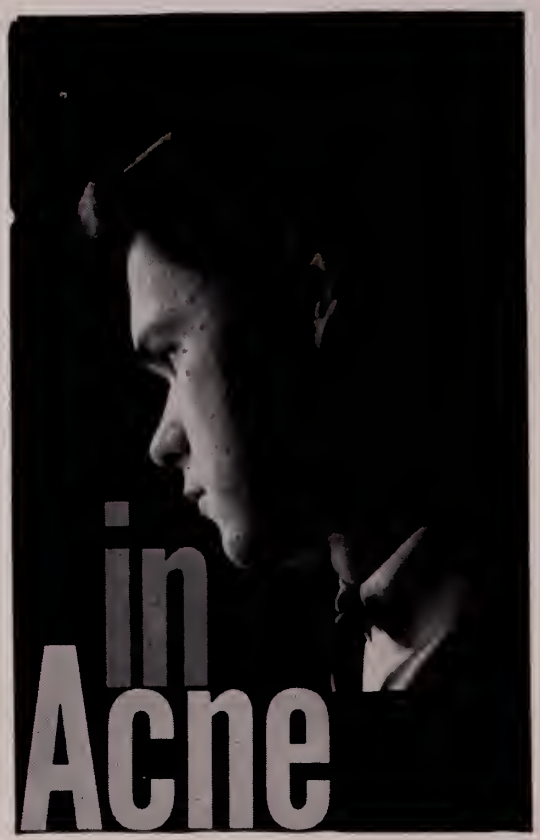
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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agents since 1938 and has worked in close cooperation with the Explosives Division of the United States Bureau of Mines in Pittsburgh.

Since static electricity is the cause of a high percentage of explosions from flammable anesthetic agents, Dr. Thomas demonstrated how static can be generated in the breathing apparatus of gas machines and can be the cause of explosions of such anesthetic mixtures as cyclopropane-oxygen, ethylene-oxygen, ether-oxygen or nitrous oxide-oxygen-ether.

The demonstration also showed the manner in which static electricity may be generated on woolen blankets, nylon, silk, or sharkskin uniforms, rubber or composition soled shoes, and nonconductive rubber table mattresses used in operating and delivery rooms.

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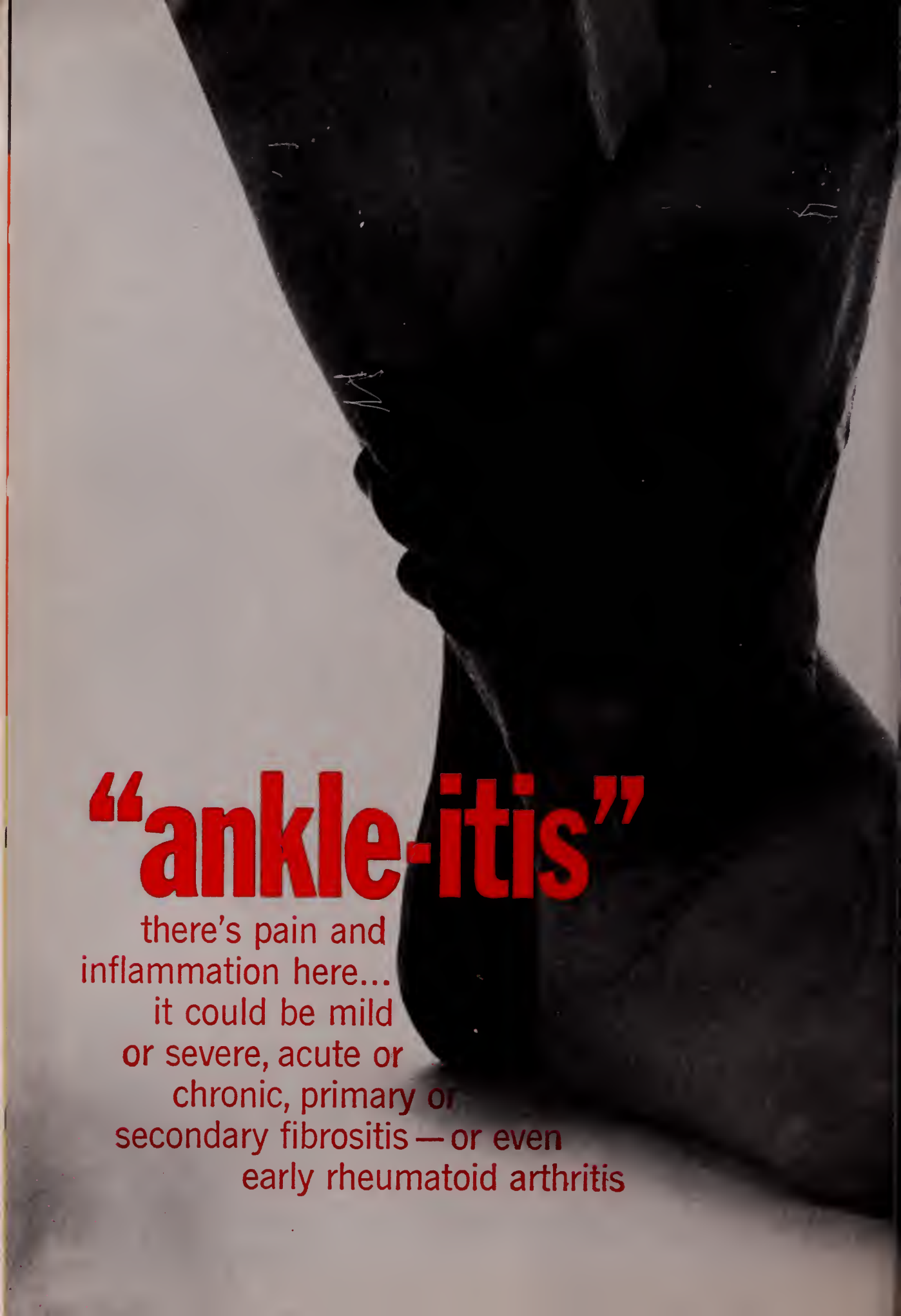
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assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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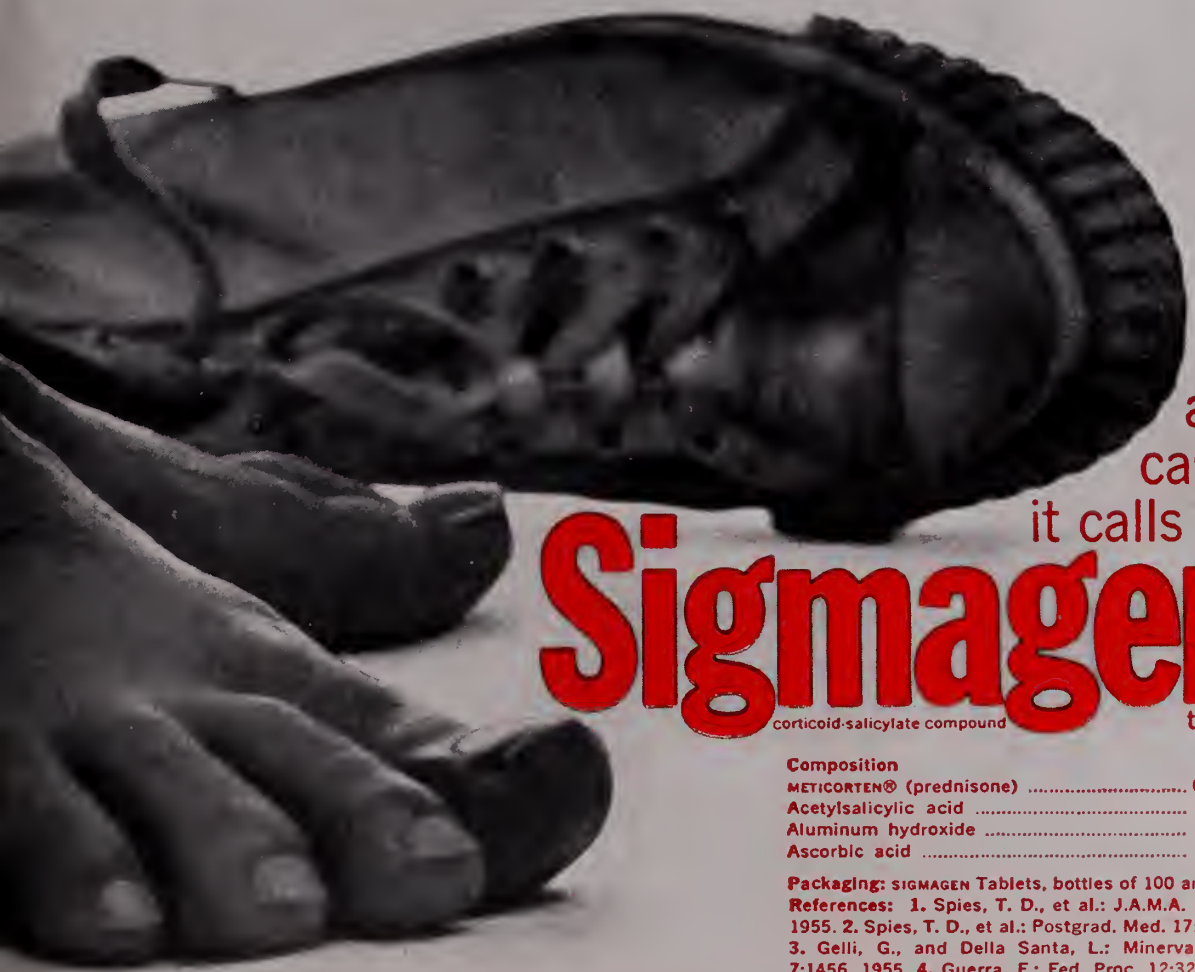
much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

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acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

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METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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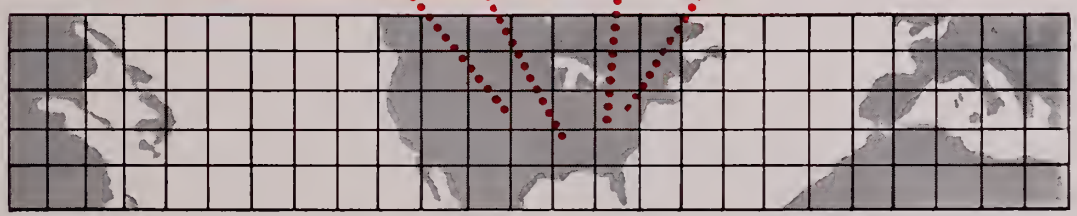
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ATARAX is "effective in controlling tension and anxiety... Its safety makes it an excellent drug for out-patient use in office practice."[4]



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For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
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For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Beeler, Robert V. Jr., Sarasota
Bichard, Phillip M., Leesburg
Booher, David O., Jacksonville
Caffey, John W. Jr., Jacksonville
Cerrato, Calvin M., Fort Lauderdale.
Chriss, George S., Jacksonville
Cranford, James A. Jr., Jacksonville
Fealy, Jack, West Palm Beach
Fernandez, Manuel C., Miami
Forrester, Eugene N., Winter Park
Green, Quentin L., Orlando
Houston, William H. Jr., Jacksonville
Jones, Ralph Jr., Miami
Leone, William A., Miami
Lewis, Edward C. II, Boca Raton
McNeil, James P. Jr., Jacksonville
Mantooth, Murray K., Jacksonville
Murphy, William P. Jr., Miami
Nobo, Jacinto L., Coral Gables
Reinherz, Albert, Tavernier
Reynolds, David H., Miami
Russell, Anne P., Miami
Schwab, John E., West Palm Beach
Shaw, J. William, Jacksonville
Shultz, Clifford J., Orlando
Still, Robert H. Jr., Jacksonville
Strachan, James B. Jr., Jacksonville
Thompson, Chester M., Orlando
Tolmach, Robert S., Miami
Trombley, Joseph J. Jr., Pompano Beach
Walker, James W., Jacksonville
Williams, Moke W., Fort Lauderdale
Williams, William T., Dunedin
Witten, Samuel B., Jacksonville

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for the aged patient

. . . when mental decline
is complicated by
marked agitation

NICOZOL w/Reserpine

helps reverse cerebral
deterioration . . . while it
stimulates body function . . .
and calms the emotions.

for a 3-way synergistic action . . .

Each tablet NICOZOL w/Reserpine contains:

Pentylenetetrazol	100 mg.	(cerebral stimulant & analeptic)
Niacin	50 mg.	(vasodilator)
Reserpine	0.25 mg.	(tranquilizer-sedative)

Clinically Established[1, 2]

n studies of 75 patients (average age—72), with typical nental and emotional symptoms together with alternate periods of depression and agitation, 87% showed gratifying esponse to NICOZOL w/RESERPINE.

"This therapy afforded relief of agitation . . . improved memory, behavior, sociability, appearance and tidiness. Symptoms of confusion, aggressiveness, hostility and disorientation also were relieved." Fewer side effects were noted.

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". . . patients who otherwise would have required institutionalized care were managed at home . . . ."[2]

Prescribed early, NICOZOL w/RESERPINE may avoid "later commitment to nursing homes or state hospitals."[1, 2]

1. Proctor, R. C.: Clin. Med. 6: 717 (June) 1957
2. Proctor, H. ., Bailey, W. H. and Morehouse, W. G.: J. Am. Geriatrics Soc. (April) 1958.

OBITUARIES

DeWitt Talmage Smith

Dr. DeWitt Talmage Smith of Gainesville died of a cerebral hemorrhage at the Alachua General Hospital on Sept. 23, 1958. He was 77 years of age.

Born in Evergreen, Ala., on Nov. 20, 1880, Dr. Smith received his medical education in his native state. He was graduated from the Medical College of Alabama in 1907, and was also a graduate pharmacist. Locating in Florida, he first engaged in the general practice of medicine in Pensacola. He soon went to Chicago for special training in ophthalmology and otolaryngology and returned to Florida to practice that specialty in Gainesville for nearly half a century, retiring in 1956.

Locally, Dr. Smith was active in civic affairs and in 1926 served on the City Council. He was a member of the First Methodist Church and was active on its building committee.

Dr. Smith was a member of the Alachua County Medical Society and was a life member of the Florida Medical Association. He was also a life member of the American Medical Association and held membership in his specialty societies.

Surviving are the widow; two daughters, Mrs. Earl C. Deck and Mrs. Bayard H. Strom Jr., both of Gainesville; two sisters, Mrs. Alfred Zimmerman, of Dallas, Texas, and Mrs. Josephine Griffin, of Evergreen, Ala.; and four grandchildren.

BIRTHS AND DEATHS

Births

Dr. and Mrs. M. Murray Schechter of Miami announce the birth of a daughter, Tracye Karen, on October 25, 1958.

Dr. and Mrs. Arthur R. Nelson of Jacksonville announce the birth of a son, Jeffrey Mann, on September 21, 1958.

Dr. and Mrs. Jonathan H. Wood of Jacksonville announce the birth of a daughter, Susan Franklin, on November 5, 1958.

Dr. and Mrs. Edwin E. Sapp of Jacksonville announce the birth of a daughter, Donna Marie, on October 1, 1958.

Dr. and Mrs. Joseph D. Foley of Jacksonville announce the birth of a son, Barry Greg, on November 6, 1958.

Death — Members

Aronovitz, Samuel, Miami ..... October 27, 1958



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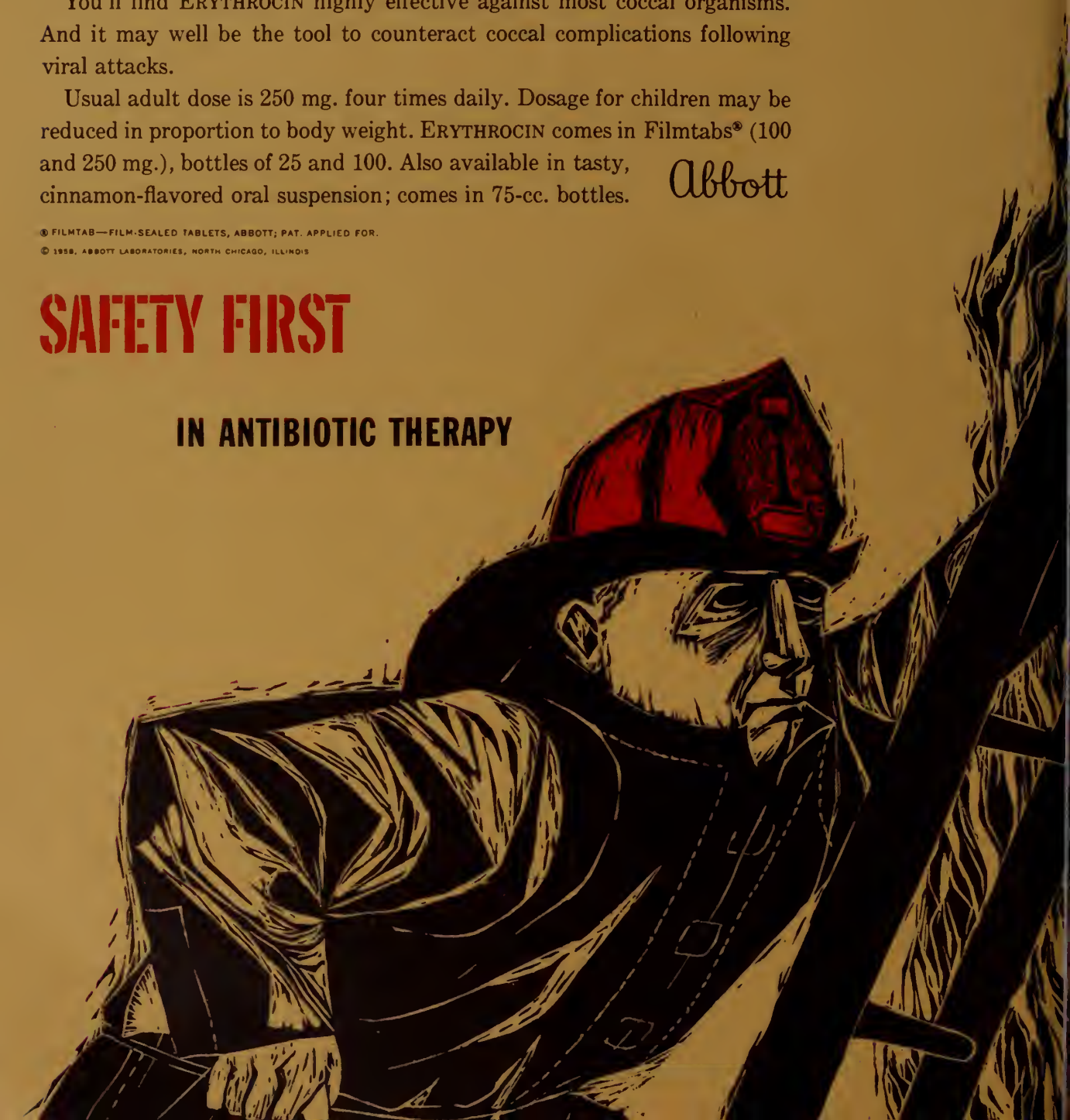
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FOR RELIEF OF ANXIETY
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Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
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Has not produced hypotension,
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through vomiting or diarrhea—

Valentine's MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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A Letter From the President of the Woman's Auxiliary To the Members of the Florida Medical Association

Dear Doctors:

American Medical Association leaders are constantly reminding the members of the Woman's Auxiliary that in today's changing world, medicine needs all its allies: and for this reason, many requests for assistance from the Auxiliary, particularly relating to socioeconomic conditions confronting American medicine today, have been made. Examples of these numerous and varied requests are: In the field of legislation, the A.M.A. has asked the Auxiliary to study and understand certain impending legislation and to provide a system for informing leaders of other organizations of medicine's position concerning this legislation. The A.M.A. has asked that the Auxiliary cooperate with the national, state and local medical societies in their new programs to improve the health of the aged. The A.M.A. wants contributions from the Auxiliary for the American Medical Education Foundation, medicine's organization for the private financial support of medical schools. The Auxiliary continues to be called upon for the promotion of circulation of Today's Health, your magazine for getting health information to the lay public. In the field of recruitment of students for paramedical careers, the Association continues to seek aid from the Auxiliary.

In the December issue of this Journal, you read of the state Auxiliary's Fall Conference for County Auxiliary Officers and Committee Chairmen held in Daytona Beach. At this meeting, requests, inspiration and guidance to the Auxiliary leaders were given by leaders of the Florida Medical Association. These men were Dr. Jere W. Annis, your Association President; Dr. Willard E. Manry, representing your Advisory Committee to the Auxiliary; Dr. Edward Jelks, President of the Florida Medical Foundation; Dr. Louis M. Orr, President-Elect of the American Medical Association, and Mr. Leyton Hunter,

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Sulfamethoxypyridazine Lederle

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Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Lederle

*Reg. U. S. Pat. Off.

representing the Florida Medical Association's Disability Insurance Plan. It is hoped that medicine in Florida is already receiving more assistance from the members of the Auxiliary as a result of their suggestions and advice.

At the Florida Medical Association's Conference for County Medical Society Presidents and Secretaries, held December 14 in Jacksonville, the local medical society leaders were reminded by Dr. Annis that more active use of one of medicine's important allies, the medical Auxiliary, can prove very helpful and meaningful to the local societies.

On the local level, many medical societies have called upon us to execute tasks of all kinds. Our activities have been numerous and again look at some examples for demonstration. We have staffed exhibits at fairs, sponsored local health drives, supplied other local organizations with health information for their programs, given scholarships to worthy students, and—on and on!

We take a great deal of pride in the fact that the Auxiliary has answered many requests for service from the A.M.A., the F.M.A. and from many local medical societies, but the cause of organized medicine can be aided even more in many localities. We Auxiliary members believe in the ideals of American medicine and our lot is cast with you members of the medical profession. We are so very proud to belong to an organization whose chief objective is to "assist the medical association in its program for the advancement of medicine and public health."

Please remember that we are ready at all times to carry out this objective and to help in fulfilling the true meaning of Auxiliary—to confer help or aid; to assist or to support, to serve as a supplement.

You men of the local medical societies, please call on your Auxiliary. Whatever your request—the county Auxiliaries want to assist you and serve as your supplement!

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BOOKS RECEIVED

Amid Masters of Twentieth Century Medicine. *A Panorama of Persons and Pictures.* By Leonard G. Rowntree, M.D. Pp. 684. Illustrated. Price, $11.50. Springfield, Ill., Charles C. Thomas, Publisher, 1958.

This book is neither a history of the medicine of recent times, nor an autobiography, but rather the record of medicine as the distinguished author has seen it unfold during his active medical career. "Herein," Dr. Rowntree states in the Prologue, "I have endeavored to do what was done by Defoe in his *Memoirs of a Cavalier*, and by Churchill in *The Gathering Storm*. 'To hang momentous developments' in medicine 'upon the slender thread of my personal experiences.' This accounts for my ubiquitous presence in the volume. Here, indeed, you are supposed to see through my eyes a revealing panorama of the medicine of the Twentieth Century. Here you meet with some of medicine's outstanding personalities and institutions, and the changes they have wrought in medical thought and training, and, in medical investigation and practice."

During a brilliant career spanning half a century, Dr. Rowntree witnessed the medical miracles performed in this most productive era of medical history and has been in a position to know personally the leaders of contemporary medicine and the problems they faced. Born in London, Ontario, he was graduated from the Western Ontario Medical School and had served an internship before coming to the United States in 1906. After embarking on a career in academic medicine at the Johns Hopkins University School of Medicine, he was soon invited into the clinical field there as associate professor of medicine in the now famous experiment which brought into existence for the first time on this continent full time clinical teaching. In 1916, he took the chair of medicine at the University of Minnesota and four years later began 12 years of service as Chief of Medicine in the Mayo Foundation, as professor of medicine in the graduate school, as director of clinical investigation, and as senior medical consultant in the Clinic. In 1932 he became director of the Philadelphia Institute for Medical Research. In World War I, he was Executive Officer of the Air Service (medical) in the American Expeditionary Force and in World War II, he was Chief of Medicine at National Headquarters of Selective Service. Since then, he has been Chief Medical Advisor and Chairman of the Medical Advisory Board of the American Legion.

After World War II, Dr. Rowntree became a resident of Miami Beach and was the first internist ever to venture into a purely consultation practice in the Miami area. His name has for 12 years been one of the most distinguished on the roster of the Florida Medical Association. He was a co-founder of the University of Miami School of Medicine, and his major role in the establishment of that institution makes a noteworthy chapter in the history of medical education in Florida.

Beginning with the conquest of yellow fever and ending with the introduction of polio vaccine and the discovery of primary aldosteronism in 1956, Dr. Rowntree unfolds the record of medicine as he saw it develop over 55 years. He devotes principal parts of the book to the great medical discoveries of the last six decades, the men who made these discoveries, and some leading schools of medicine. Included are anecdotes of many of his experiences, some of his researches, and discussions of some of his patients, especially those whose progress in medicine resulted from new procedures or measures. Drawing on his broad experience, he concludes with an epilogue in which he expresses his opinions on many medical subjects. Lavishly illustrated, the book is indeed a panorama of persons and pictures from the facile pen of a great man of modern medicine.

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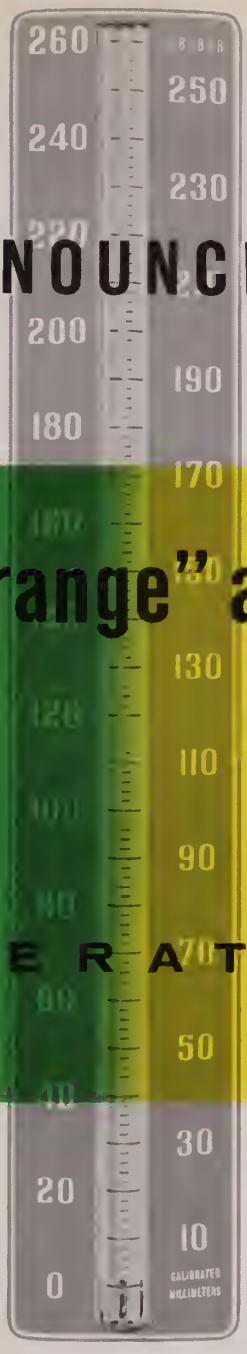
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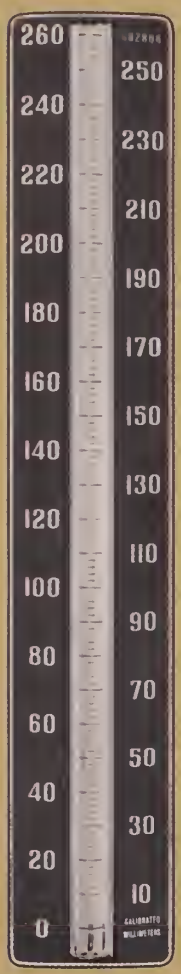
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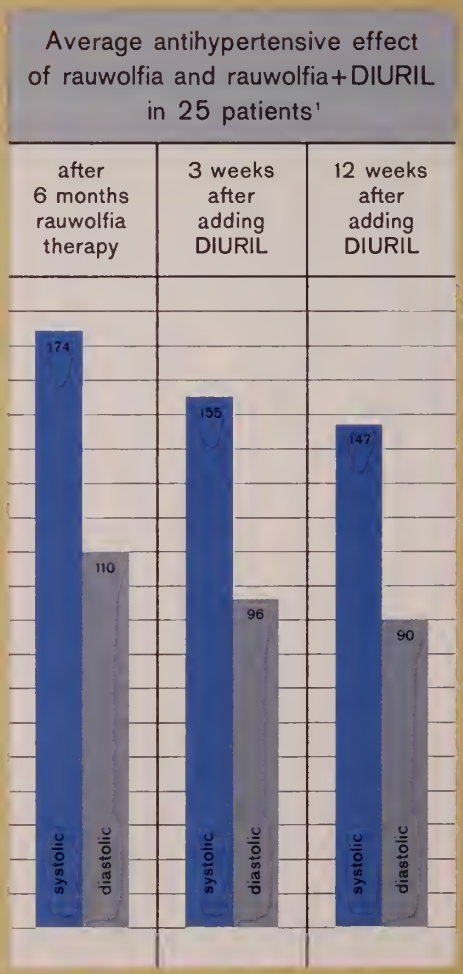
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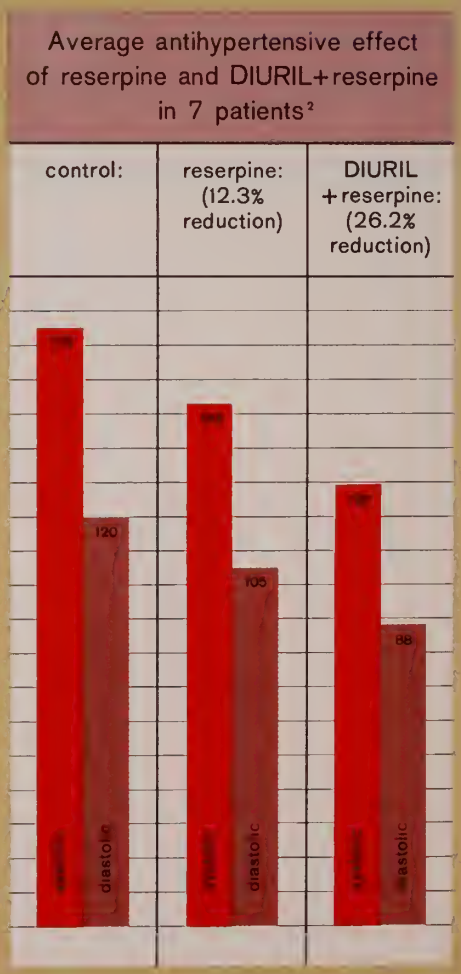
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DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

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With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

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DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

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DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

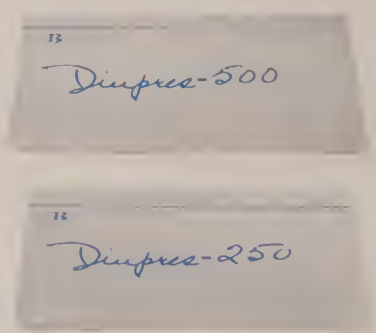
- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.
If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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Difficult Diagnosis. *A Guide to the Interpretation of Obscure Illness.* By H. J. Roberts, M.D. Pp. 913. Illustrated. Price, $19.00. Philadelphia, W. B. Saunders Company, 1958.

Designed as a postgraduate supplement to standard textbooks of diagnosis, this unique book begins where they stop. It offers a remarkable guide to the interpretation of obscure illness and becomes an invaluable aid in analyzing the puzzling case, the persistent disorder that fits no pattern and defies solution with standard diagnosis. The first portion of the book covers groupings of related diseases which frequently produce obscure illness, such as endocrinopathies, metabolic disorders, fever of obscure origin, dyscollagenoses, and iatrogenic illness. The second part discusses every special diagnostic procedure which has value in today's practice of medicine, with notes on the technic of performance and the reliability and significance of results. There is helpful discussion of such newer disease entities as cytomegalic inclusion disease, primary aldosteronism, pulmonary microlithiasis, epidemic neuromyasthenia and "pulseless disease." There is also much new material in the coverage of chlorothiazide as a precipitating cause of hepatic coma, technics of sex chromosome studies, phosphorus deprivation test, pulmonary resection tolerance test and screening tests for unilateral renal disease in hypertension.

The author, Dr. Hyman J. Roberts of West Palm Beach, is a distinguished Florida practicing internist and member of the Florida Medical Association who is a former teacher of medicine at Tufts University Medical School and Georgetown Medical School. His primary concern in this book is not with the fully developed classic syndrome, but rather the earlier atypical manifestations. He discusses baffling cases of apathetic hyperthyroidism, "preleukemic" leukemia, myeloma and other diseases. He devotes an entire chapter to obscure postoperative complications and another to the medical-surgical problems of abdominal pain, gastrointestinal hemorrhage and intestinal obstruction.

A separate 64 page Atlas of Systemic Dermadromes pictures cutaneous manifestations of scores of systemic disorders, and there is a thumb-tabbed index on Signs, Symptoms and Laboratory Manifestations. If a patient exhibits edema, for example, one can quickly locate the diseases and disorders in which such a symptom may be present. The 3,000 bibliographic references are all pertinent, recent and well chosen. Each chapter is introduced with an extensive and explicit breakdown of Contents, permitting fast and easy use. Extensive cross-referencing enables one to relate divergent information in developing a diagnosis.

Elaborating as it does on those conditions which are commonly overlooked or not well comprehended by most physicians, this remarkably useful source of otherwise hard-to-find information on the diagnosis of obscure and puzzling illnesses will be welcomed by general practitioners and surgeons as well as by internists. "I am certain of one reason why I undertook the writing," Dr. Roberts commented in the Preface, "I needed a book like this in my own practice."

The Care of the Geriatric Patient. Edited by E. V. Cowdry, Ph.D., Sc.D.(Hon.) Pp. 438. Price, $8.00. St. Louis, The C. V. Mosby Company, 1958.

This book approaches the problem of caring for the geriatric patient by anticipating the medical problems likely to be faced by older people and by working toward the prevention of their development insofar as possible. Disregarding the complacent attitude that aging and the resulting suffering are but natural in older people, it offers sound advice on their practical comprehensive care. There are 22 contributors, each an eminent authority, and in the 19 chapters they keep attention focused not on past developments, nor on help that may become available in the future, but on what is and can be supplied to physicians today. Among them



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is Dr. Louis M. Orr of Orlando, who contributed the chapter on Surgical Aspects of Geriatric Care.

Addressed to the physician in his high calling as guide, philosopher and friend, this book is designed to show how to keep geriatric patients well and active as long as possible and how to utilize recent developments and advances to do so. It contains all that is currently known about the practical, comprehensive care of geriatric patients, including medical, dental, psychiatric, social, economic and nutritional aspects. Valuable discussions on how to obtain community help, on medical care in the patient's own home and on the selection of a good nursing home add to the completeness with which the authors treat the subject.

Dietary Prevention and Treatment of Heart Disease. By John W. Gofman, Ph.D., M.D., Alex V. Nichols, Ph.D., and E. Virginia Dobbin. Pp. 256. Price $3.95. New York, G. P. Putnam's Sons, 1958.

During the last decade intensive medical research has discovered new ways both to prevent and to treat heart disease, and this authoritative new book answers the widespread demand for a clear understanding of recent medical discoveries. Here is presented a new medical concept—heart disease prevention. The reader discovers how and why to plan a diet that will help prevent heart disease, or that will greatly benefit the patient who already has heart disease. The book was written because the three authors, each an eminent authority, felt strongly that the promising results of modern heart research should be placed at the disposal of the medical profession and the general public—and translated into practical steps that every intelligent adult can follow. They present the most up-to-date information available, showing what the proper diet can do to prevent heart disease and outlining a dietary program consistent with maintaining all the elements of a well balanced, sound nutrition, according to the best nutritional knowledge available. With this book every housewife can have an authoritative guide for nutritious cookery aimed at lowering the risk of heart disease in the family. It is stated that already the patients of 5,000 physicians in all parts of the United States are following the diet recommended in this new book.

The Ethical Basis of Medical Practice. By Willard L. Sperry. Pp. 185. Price, $3.50. New York, Paul B. Hoeber, Inc., 1956.

The central problems of medical ethics are as old as Hippocrates and as contemporary as today's newspaper. They concern the patient, his relatives, and society at large as well as the physician and his conscience. This volume grew spontaneously out of a lecture given to house officers at the Massachusetts General Hospital by Dean Willard L. Sperry of the Harvard Divinity School at the invitation of Dr. J. Howard Means, Jackson Professor of Clinical Medicine in the Harvard Medical School and Chief of the Medical Services at the Massachusetts General Hospital. So clear and helpful—and above all—so thought-provoking was Dean Sperry's presentation that word of it spread through the medical profession. Professors at widely separated medical schools urged that this book be written, both for practitioners and medical students. Dean Sperry is more concerned with defining and clarifying the basic moral problems that confront the physician than with providing a ready-made set of answers. Rich in allusions ranging from the teachings of earliest times to those of Richard Cabot and the life and writings of Albert Schweitzer, this readable book, now in its third printing, considers such topics as the general relations of science and ethics, the basic distinction between a profession and a trade, the influence of special-

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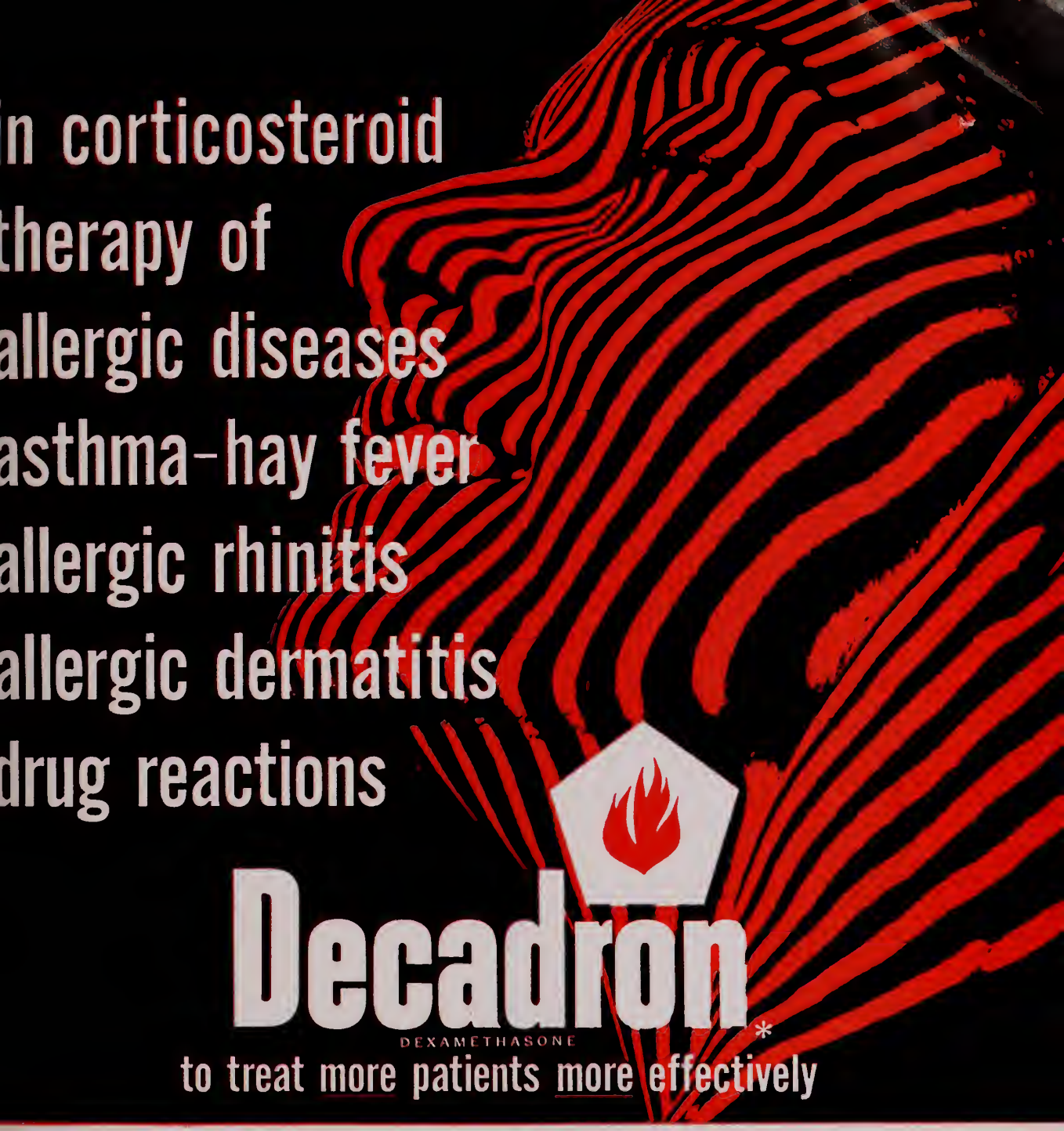
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ization upon ethical standards, and the meaning of "reverence for life" to the modern scientist. Two well balanced chapters are devoted to the pros and cons of euthanasia. Throughout the book, the reader—physician, pastor or patient—will find clarity, penetrating vision, and a wise absence of dogma.

Diagnostic Medical Parasitology. By Edward K. Markell, Ph.D., M.D., and Marietta Voge, M.A., Ph.D. Pp. 276. Illus. 115. Price, $7.00. Philadelphia, W. B. Saunders Company, 1958.

The arrangement of subject matter in this book follows, with some modifications, that of the course in Infectious Diseases presented at the School of Medicine, University of California, Los Angeles. The various infectious agents which may cause enteric disease. The their effects upon the host, and to the part or parts of the body which they infect. Thus, while certain periods are devoted to the enteric protozoa and helminths, these are but part of an over-all consideration of the infectious agents which may cause enteric disease. The primary purpose of the book is to serve as a guide both to laboratory and to clinical diagnosis of the protozoan and helminthic diseases of medical importance in this country, and to a lesser extent to the arthropods in relation to disease. While intended primarily for the medical student, it should prove equally useful to the medical technologist and all others concerned with the laboratory identification of the animal parasites of man. The success of the cooperative diagnostic efforts of the physician and laboratory technologist depends upon a mutual appreciation of their several problems. In the chapters dealing with technical methods, the problems of the technologist are discussed; the physician will be able better to utilize his laboratory service if he understands them. The numerous illustrations are largely original and have been planned to emphasize points of diagnostic importance.

Strabismus Ophthalmic Symposium II. Edited by James H. Allen, M.D. Pp. 552. Illus. 251. Price, $16.00. St. Louis, The C. V. Mosby Company, 1958.

This volume is based on the second Symposium on Strabismus sponsored by the New Orleans Academy of Ophthalmology. In so far as possible the panel was composed of the same group who met six years earlier in Iowa City, Iowa, for the first Symposium of this type. The material presented again represents the viewpoints of the various authors without alteration in respect to material covered by other participants in the Symposium. The editor notes with interest in the Preface that although basic differences still exist, many differences which apparently existed in the first Symposium had been resolved through more careful use of terminology as suggested by the late Dr. Walter B. Lancaster. For that reason and because his message is still timely, two of his papers from the first Symposium are reprinted in the appendix. The eight contributors whose lectures comprise the 22 chapters are: Drs. Francis Heed Adler, Harold Whaley Brown, Hermann M. Burian, Frank D. Costerbader, Walter H. Fink, George P. Guibor, Philip Knapp and Kenneth C. Swan.

Clinical Enzymology. Edited by Gustav J. Martin, Sc.D. Pp. 241. Price, $6.00. Boston, Little, Brown and Company, 1958.

This book discusses a new field of medicine— the parenteral administration of enzymes, their systemic actions and their therapeutic effects. It is divided into sections designed to familiarize the reader with the actual clinical data available and to provide enough background material so that he can understand fully what is known

(Continued on page 858)

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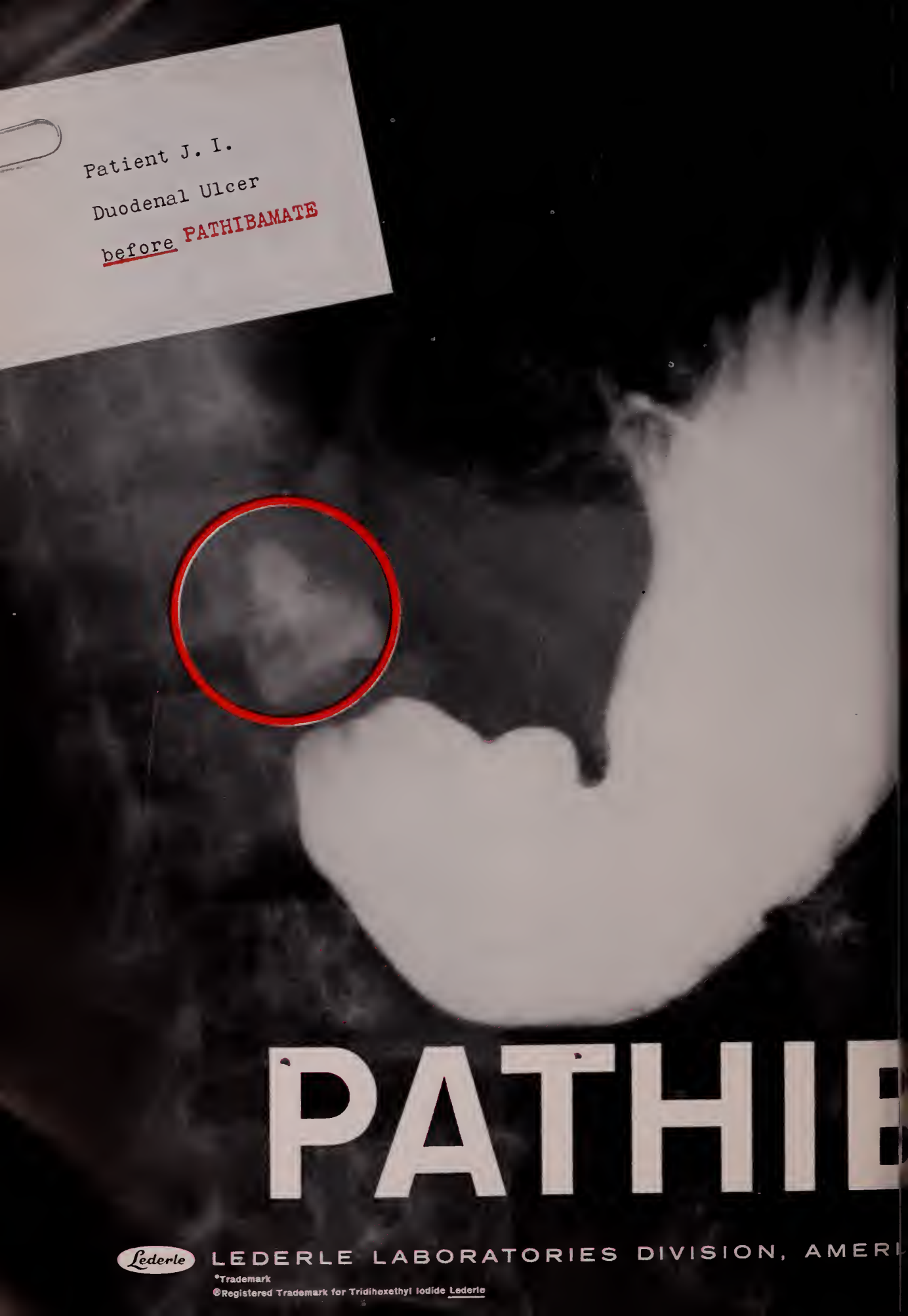
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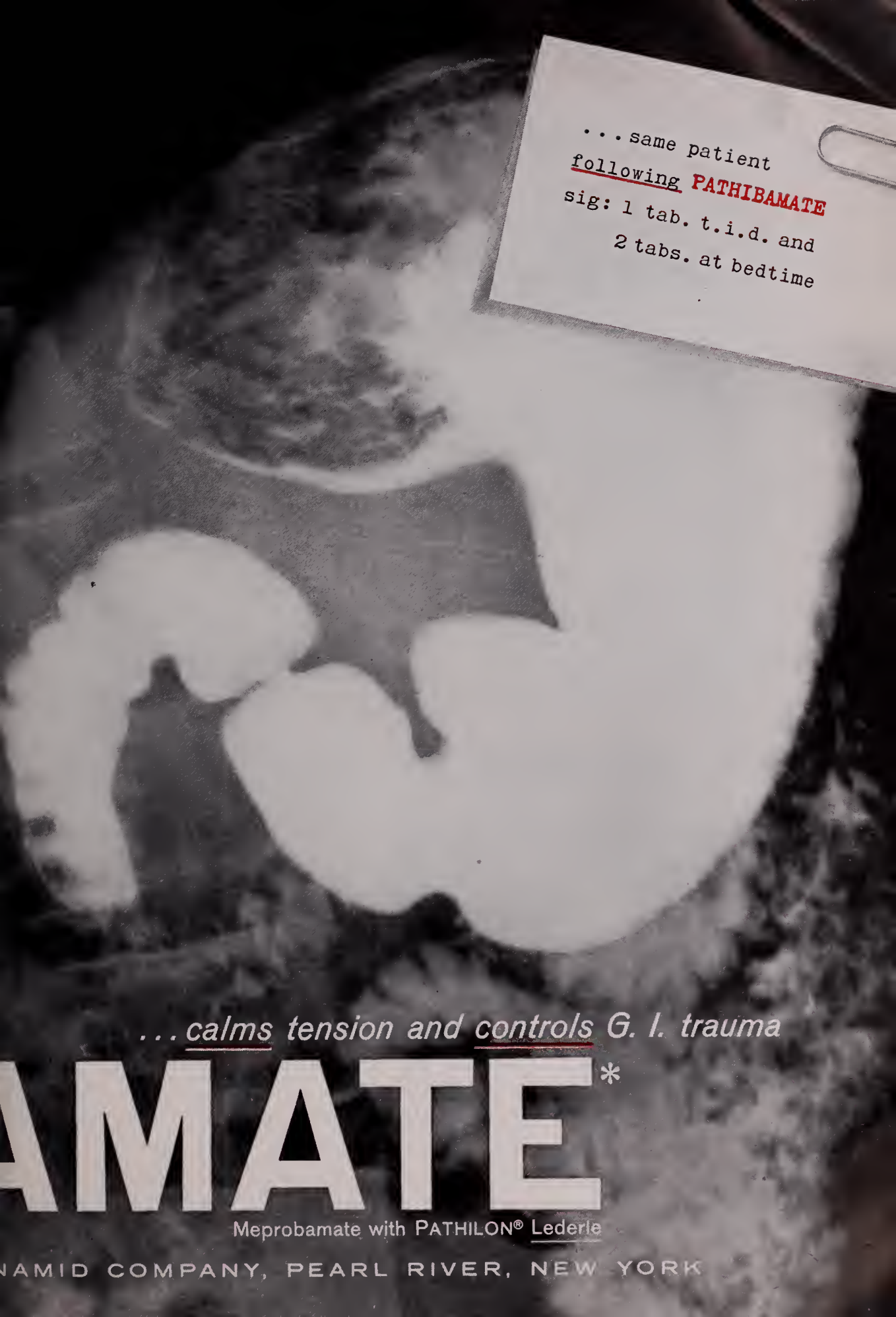
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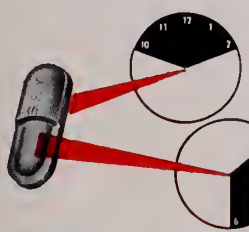
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†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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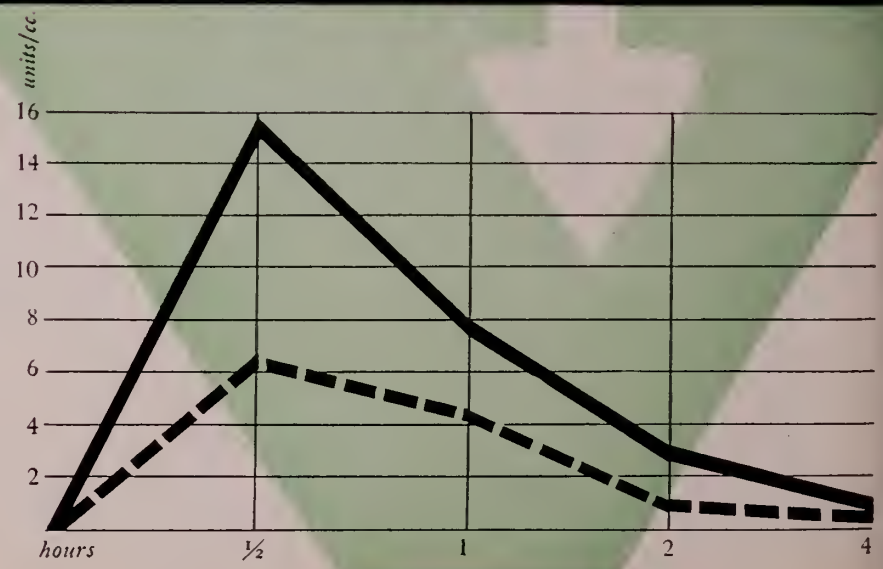
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(Continued from page 850)

about mechanisms of action and the rationale underlying the use of these biologic catalysts in therapy. The authors first present the chemistry and physical chemistry of enzymes. Next, a section is devoted to a description of the biochemical and pharmacologic characteristics of enzymes which have been used clinically, and another to a discussion of serum enzyme inhibitors and their importance in disease. Finally, the biologic equilibrium is considered in relation to the interaction of enzymes and substrates and the dependence of function on its physiologic milieu at a given time. All of these discussions serve as a setting for the presentation of the clinical phase of enzymology, which is illustrated by case reports as well as by summaries of clinical articles.

Offering an important new therapeutic approach, the book will be of special interest to physicians. For the biologic scientist it will provide for the first time a review of the systemic actions of parenterally administered enzymes. Since all phases of enzymatic actions are discussed, and these data are not available elsewhere in collected form, the student will find it a convenient reference.

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Handbook of Medical Treatment. Edited by Milton J. Chatton, M.D., Sheldon Margen, M.A., M.D., and Henry Brainerd, M.D. Ed. 6. Pp. 569. Price, $3.50. Los Altos, Calif., Lange Medical Publications, 1958.

The popularity of this Handbook has grown with each successive edition. The medical student and the practitioner of medicine alike will welcome this sixth edition for it is a practical answer to a real need. In compiling this collection of therapeutic procedures the authors reviewed a vast therapeutic literature and selected those advances they thought were most significant. Certain new drugs which have been the subject of enthusiastic reports they offer with guarded comments. Whenever they have thought that acceptance must wait upon stronger evidence based upon broader studies, they have so stated. In addition to the dramatic pharmacologic discoveries and important revisions in the concepts of diagnosis and treatment in the last two years as at all times, they regard improved understanding of dosage, toxicity, combination therapy, new forms of established remedies, and other relatively minor refinements in diagnostic and therapeutic technic as the main purpose of this Handbook and the ultimate justification for its frequent revision. The drugs are listed by their official American and British names. Common or proprietary names are given in parentheses when these are considered helpful. Code numbers of diseases are included as an aid to the student and house officer.

Electrocardiography. By Michael Bernreiter, M.D., F.A.C.P. Pp. 134. Price, $5.00. Philadelphia, J. B. Lippincott Company, 1958.

The purpose of this book is to outline the fundamental aspects of electrocardiography as they are encountered in everyday practice. Only the most basic physical principles necessary to understand the electrical phenomena of electrocardiography are discussed. Without these basic principles, the author points out in the Preface, interpretation of tracings would be reduced to "pattern memorization," an unscientific approach which overburdens and discourages the student. Schematic diagrams are shown throughout the text to clarify the electrical phenomena responsible for certain electrocardiographic patterns, and numerous electrocardiograms depict

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†Literature and bibliography available on request.

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diagnostic features of the subjects under discussion. Subjects receiving authoritative treatment based on extensive personal experience include: technical aspects, cardiac arrhythmias including AV blocks, myocardial infarction, right and left bundle branch blocks, ventricular hypertrophy, ischemia, current of injury and death of myocardium, and the effects of drugs and electrolytes on the electrocardiogram. The book is directed toward the needs of the medical student, the general practitioner and the internist. The author is Assistant Clinical Professor of Medicine at the University of Kansas Medical School and has taught graduate courses in electrocardiography for more than a decade.

Orthopedic Diseases. *Physiology-Pathology-Radiology.* By Ernest Aegerter, M.D., and John A. Kirkpatrick, Jr., M.D. Pp. 602. Illus. 354. Price, $12.50. Philadelphia, W. B. Saunders Company, 1958.

This book is concerned with the understanding of the diseases which affect the musculoskeletal system. "It is intended for the clinician who wants to increase his diagnostic efficiency, for the radiologist who is perplexed by the meaning of an overwhelming array of radiographic nuances, for the pathologist who is distraught by his inability to interpret what he sees through the microscope, for the young specialist who wants to pass his board examinations and for the medical student who must acquire a certain amount of knowledge of orthopedic diseases in order to graduate." This useful diagnostic aid shows exactly how signs and symptoms are produced by altered morphology and physiology, gives a brief review of anatomy, physiology and histology of bone tissue, and includes a primer on the fundamentals of bone radiology. For each skeletal disease it then details the clinical manifestations, radiographic and laboratory findings, and prognosis. Photomicrographs are beautifully correlated with radiograms. Diseases are grouped as: (1) Disturbances in Skeletal Development, such as achondroplasia, osteopetrosis, fibrous dysplasia, and Niemann-Pick disease: (2) Disturbances in the Formerly Normal Skeleton, such as fractures, osteoporosis, osteomalacia, Paget's disease, abnormal parathyroid function and infectious diseases; and (3) Tumors and Tumor-like Processes, such as osteogenic, chondrogenic, collagenic, myelogenic, and tumors of soft parts.

Aids to Medical Diagnosis. By G. E. Frederick Sutton, M.C., M.D. (Lond.), F.R.C.P. Ed. 8. Pp. 400. Price, $3.50. London, Baillière, Tindall and Cox, 1958. (The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.)

This handy little volume is one of the small textbooks of the Students' Aids Series published in London. It is now appearing in its eighth edition and has been thoroughly revised since its last edition five years ago. It covers infectious diseases; disorders of the abdomen; diseases of the blood, heart and blood vessels, lungs and pleurae, endocrine organs, kidney, nervous system, and joints; and the electroencephalogram.

Modern Clinical Psychiatry. By Arthur P. Noyes, M.D., and Lawrence C. Kolb, M.D. Ed. 5. Pp. 694. Price, $8.00. Philadelphia, W. B. Saunders Company, 1958.

This especially useful reference source for understanding the causes, nature, clinical symptoms and treatment for the entire range of neuroses, psychoses and personality disorders now appears in a fifth edition. It offers step-by-step guidance on examining a patient, clarifies anatomic, physiologic, and psychologic factors on mental illness, and describes every approved method of therapy. Detailed case histories illustrate important





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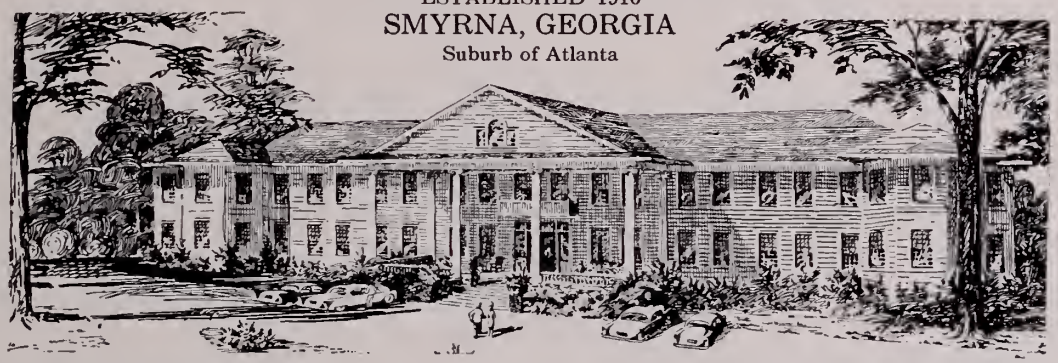
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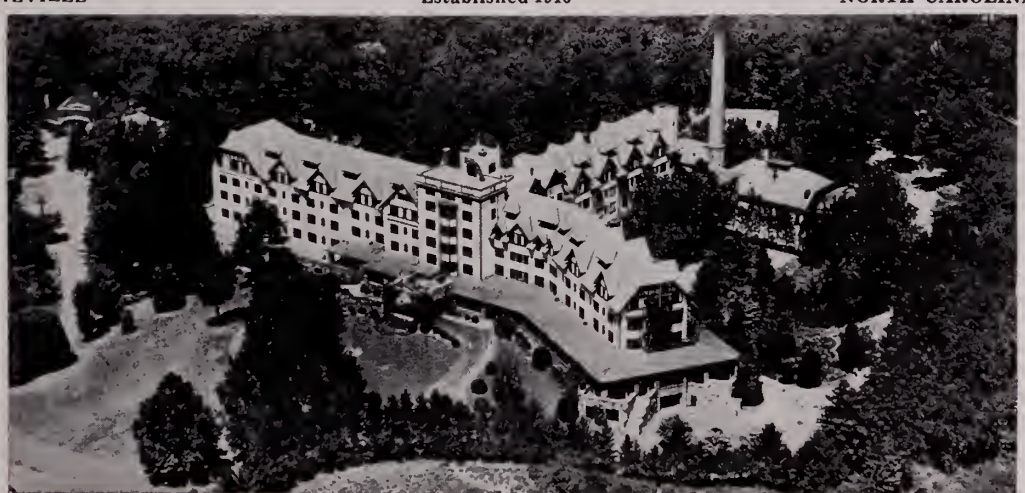
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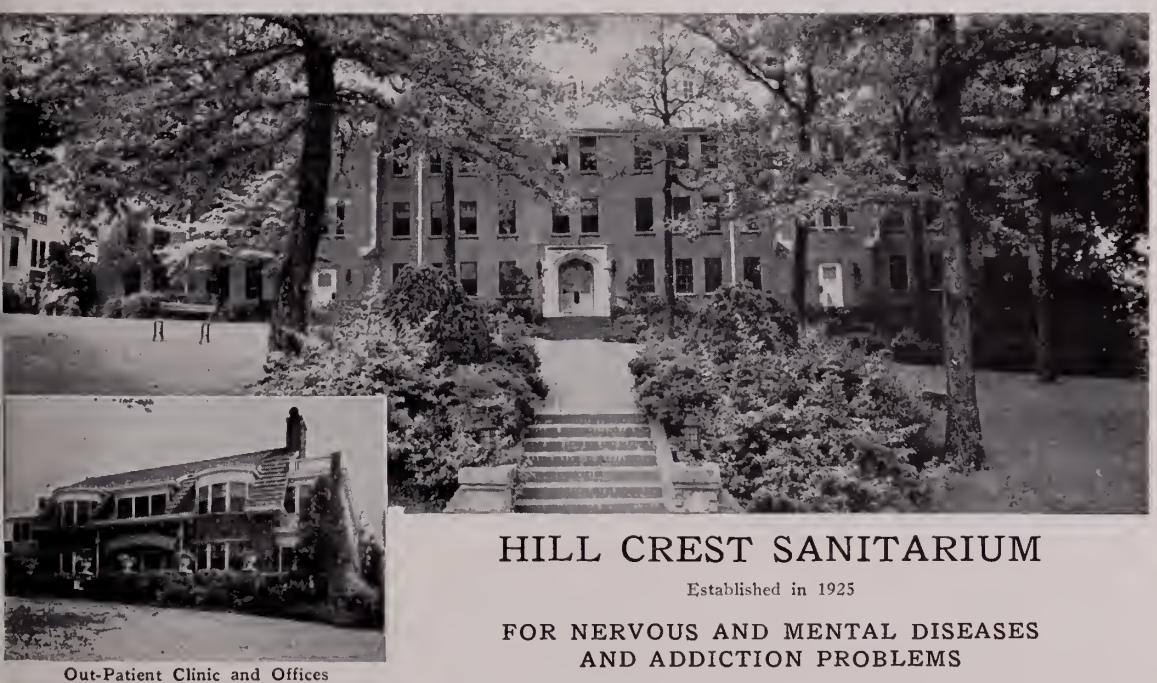
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astern Surgical Congress	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta	Miami Beach, Mar. 9-12, '59
Coast Clinical Society	William J. Atkinson, Mobile, Ala.	Dan Sullivan, Mobile, Ala.	Mobile, Ala., Oct. 1959
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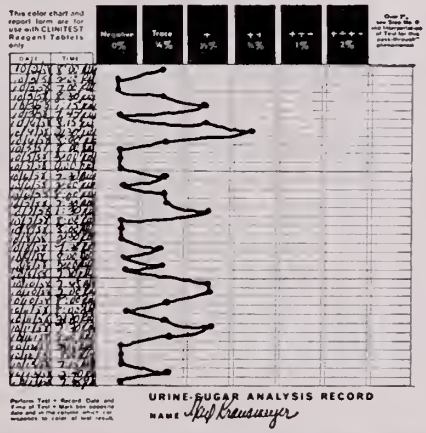
Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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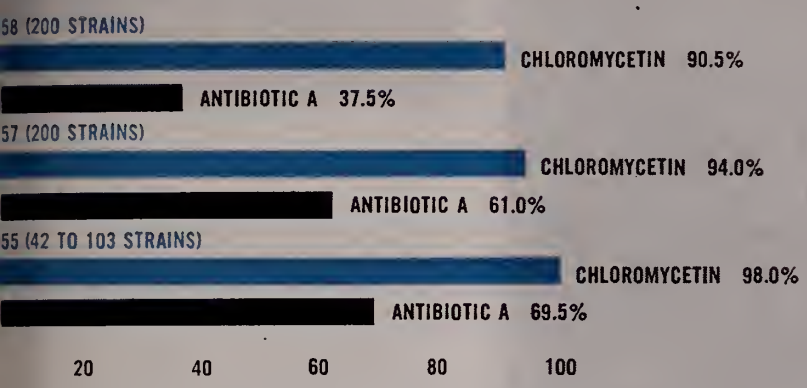
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REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., *et al.*: *Canad. M.A.* 77:844, 1957. (3) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch, H. & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair, J. E. & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, F. R., *et al.*: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, A. & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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VITRO SENSITIVITY OF PATHOGENIC STAPHYLOCOCCI TO CHLOROMYCETIN AND ANOTHER WIDELY USED BROAD-SPECTRUM ANTIBIOTIC FOR 1958, 1957, and 1955*



*Adapted from Holloway and Scott.[1] In this study CHLOROMYCETIN and Antibiotic A were used in identical strengths of 5 mcg.

71359



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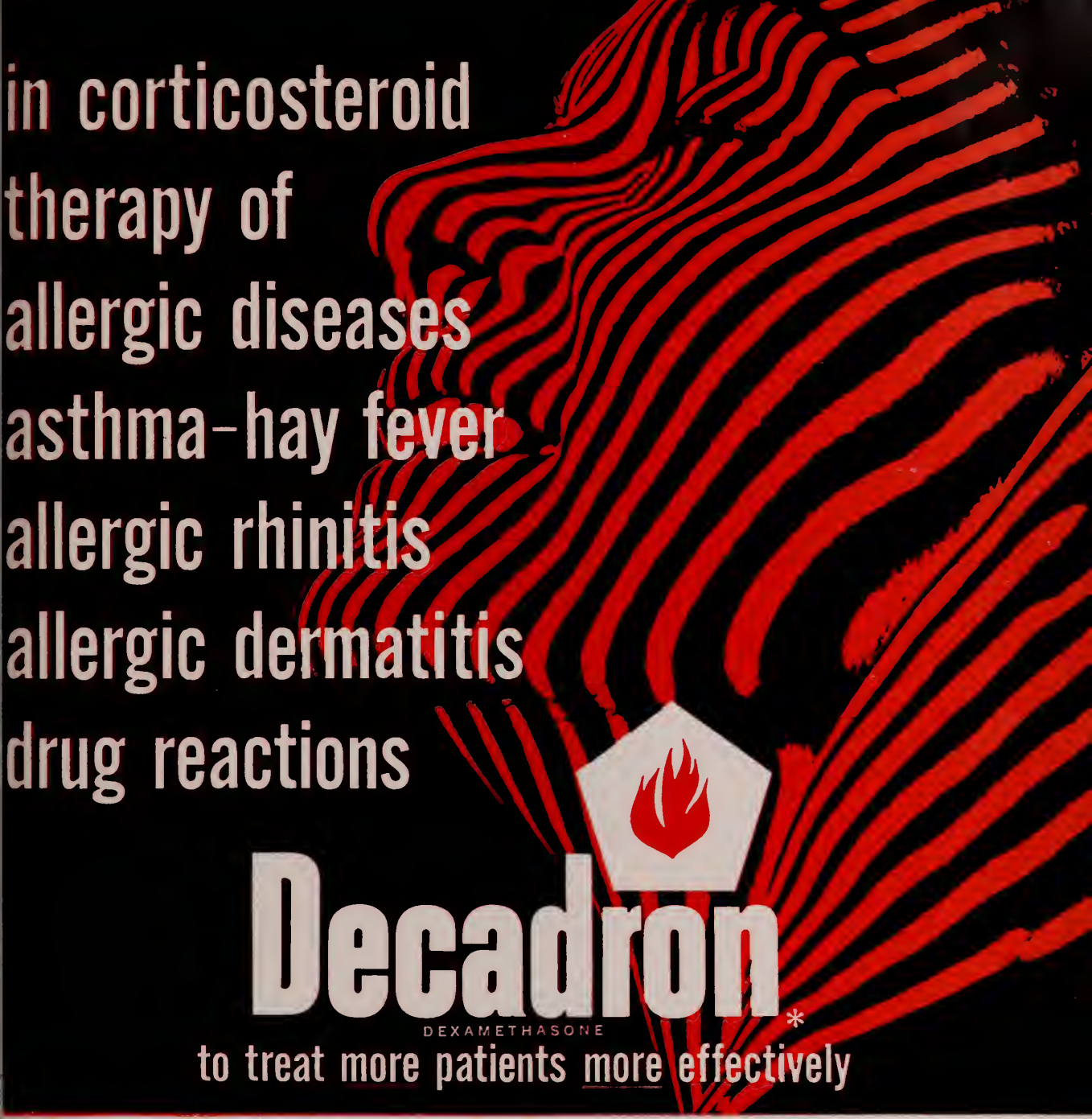
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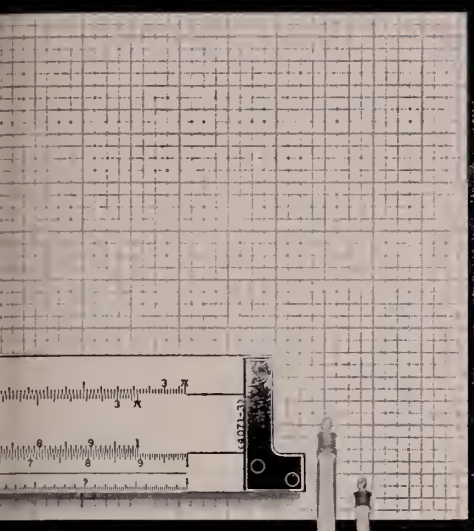


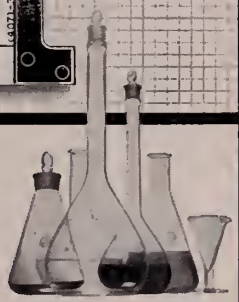


in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Fa
ALL INFECTIONS	**558**	**448**	**80**	
Respiratory infections	**258**	**208**	**31**	
Pharyngitis and/or tonsillitis	65	58	5	
Pneumonia	90	66	17	
Infectious asthma	44	38	–	
Otitis media	31	29	2	
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	
Skin and soft tissue infections	**230**	**191**	**38**	
Infected wounds, incisions and lacerations	41	33	8	
Abscesses	51	43	8	
Furunculosis	58	51	6	
Acne, pustular	43	28	15	
Pyoderma	19	19	–	
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	
Genitourinary infections	**28**	**19**	**3**	
Acute pyelitis and cystitis	10	8	2	
Urethritis with gonorrhea or cystitis	8	8	–	
Pyelonephritis	4	1	–	
Salpingitis	5	1	1	
Pelvic inflammation with endometriosis	1	1	–	
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	

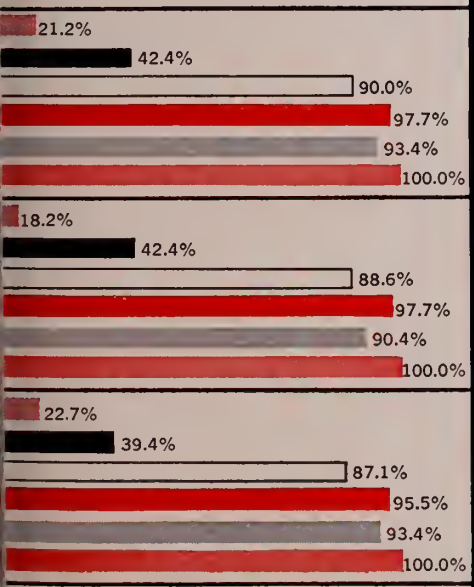




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ATIVE TESTS BY THREE METHODS
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iotic A 2-10 units — Tao 2-15 mcg.
iotic B 5-30 mcg. — Antibiotic D 2-15 mcg.
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ge of organisms inhibited by the range of
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References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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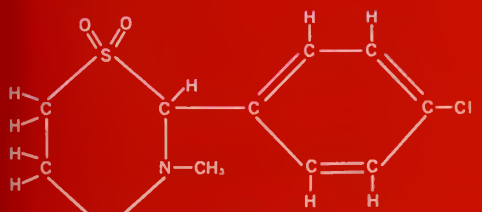
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for clinical results in 4092 patients *see inside*

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*TRANQUILAXANT**

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clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant)
[< L. tranquillus, quiet, L. laxare, to loosen, as the muscles]

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"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

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"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm*, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

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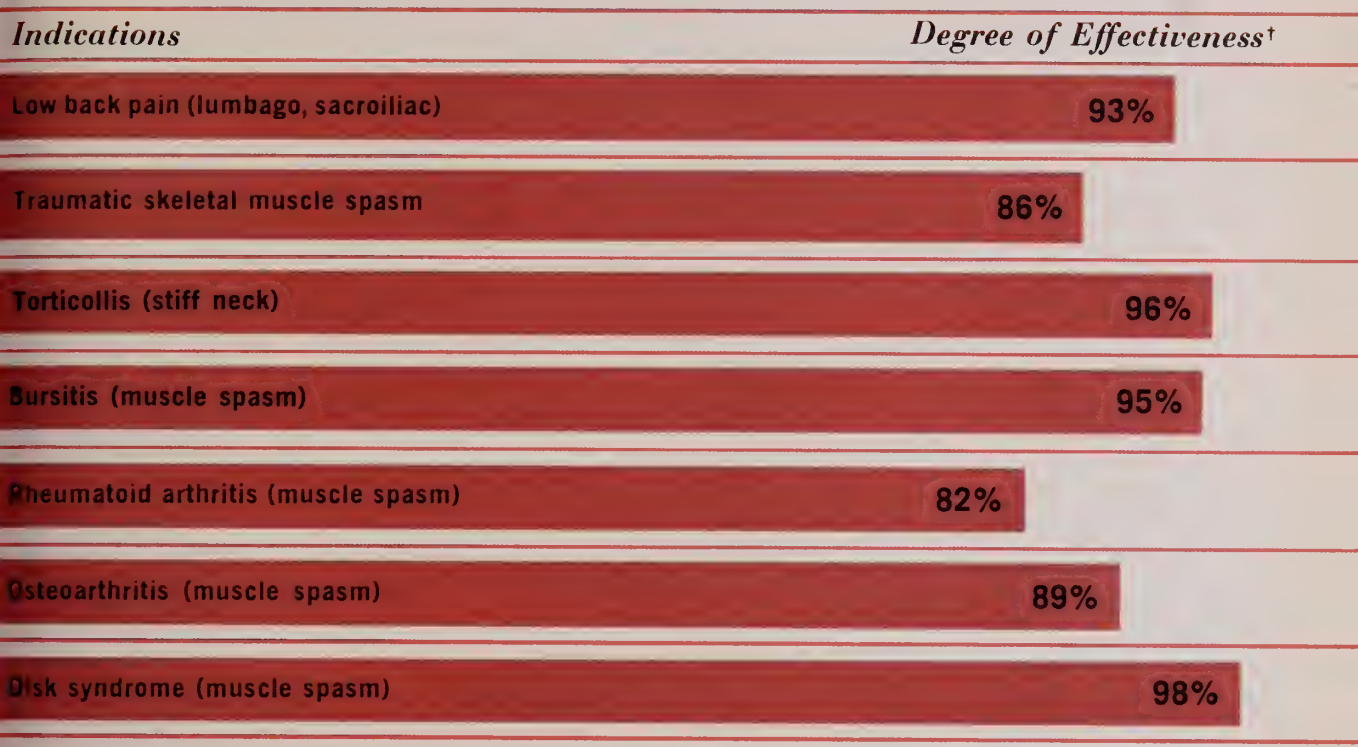
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

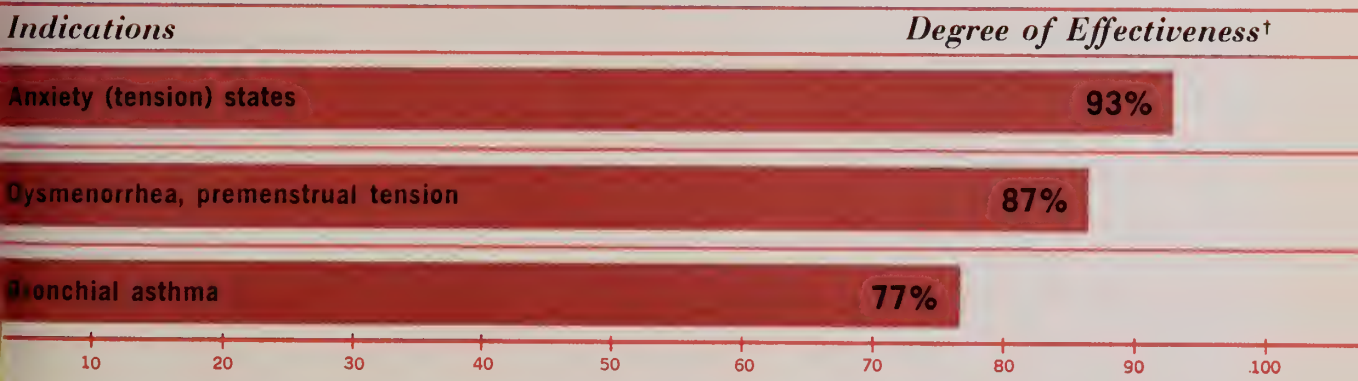
"In 120 patients with *anxiety or tension states*, 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

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†*Excellent, good and fair*

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Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
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Myositis
Postoperative myalgias

Psychogenic

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

Neurologic

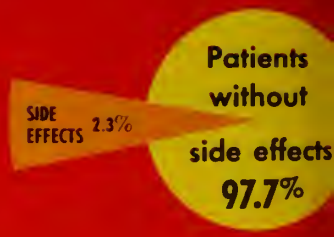
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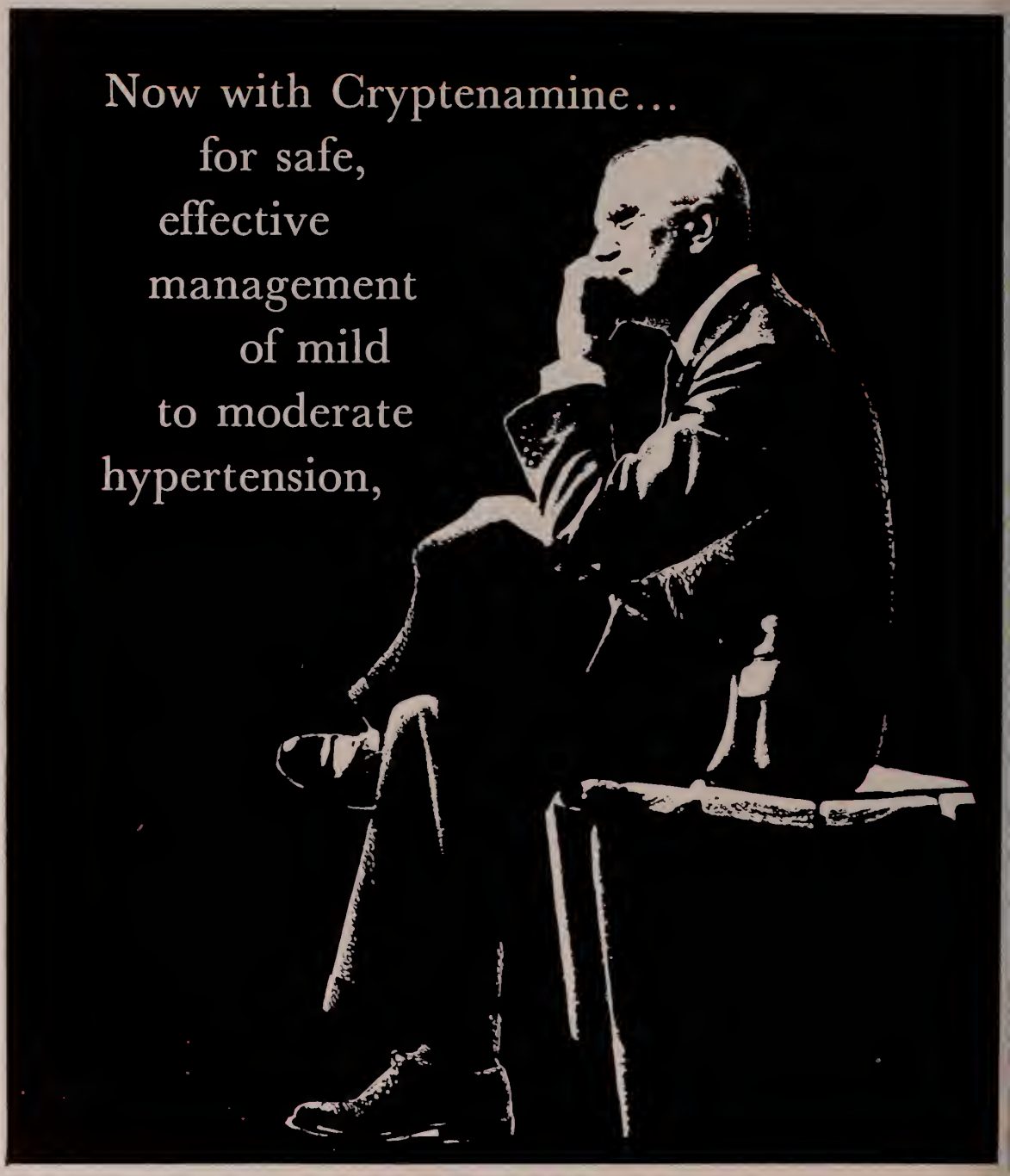


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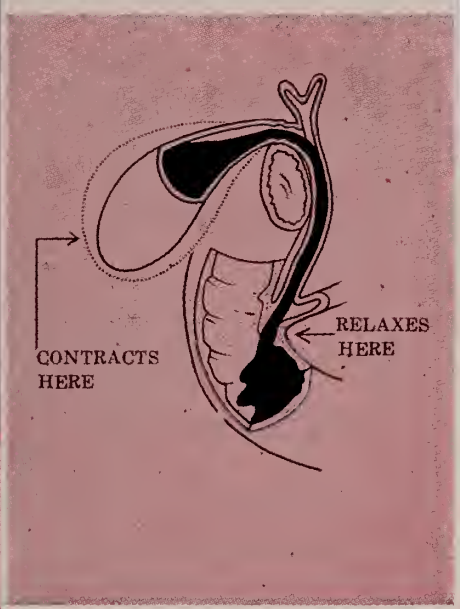
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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec, 14:196 (Dec.) 1957

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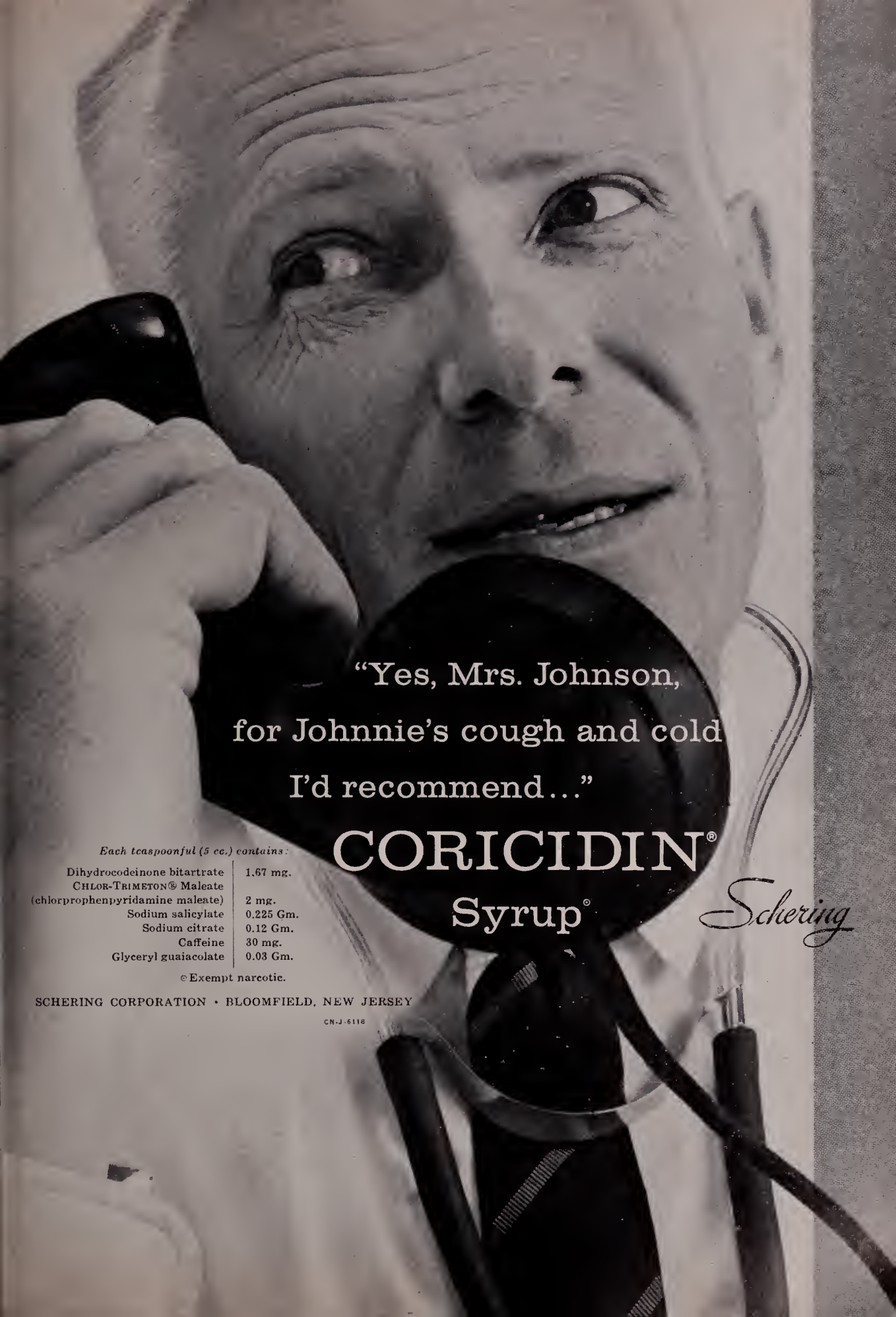
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The Use of Carbon Dioxide in the Treatment Of Postconcussion Syndromes

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This paper is an extension of a preliminary report made at the October 1957 meeting of the Eastern Psychiatric Research Association.

The postconcussion syndrome presents a perplexing problem for several reasons. First, the diagnosis has led to considerable confusion at times, inasmuch as most of the findings of this syndrome are purely subjective. There are occasional objective signs such as an abnormal electroencephalogram, disturbed vestibular function, increased spinal fluid protein, the Muck Adrenalin-Sonderversuch test,[1] and psychologic tests.[2] These objective signs, however, occur relatively infrequently, and the diagnosis is more often made without the tests and even in the absence of these findings. Generally, it is made on the finding of a combination of most of the symptoms here listed following a disturbance in consciousness after a head injury: headaches, irritability, emotional instability, dizziness including vertigo or giddiness, blurring of vision, depression, fatigue with asthenia, occasional tinnitus, recent impairment of memory, poor tolerance to alcohol, lack of ability to concentrate over prolonged periods, and loss of libido.

A second complicating factor in this problem is that most patients who have a postconcussion syndrome are involved in litigation, either in negligence cases or in industrial compensation cases. As a consequence of the economic factors of the case, it is all too frequently assumed that many of the patients are motivated by financial gain, and are either manufacturing or exaggerating symptoms, or else have "compensationitis."

The final complicating factor is a relative lack of success in the treatment of this condition. In most cases it runs a prolonged course of three to 36 months, and there is no specific treatment. The usual sedatives and analgesics are prescribed without any considerable help. Prostigmin[3] has been used with some variable success by other workers, but this therapy has not been of consistent value.

A treatment method is described in this paper which has shown considerable promise and is based on the following rationale:

Courville,[1] in his scholarly treatise "Commotio Cerebri," has shown that there are definite histologic changes occurring with the postconcussion syndrome. These changes consist mostly of chromatolysis with progressive dissolution of the tigroid granules in the nerve cells of the cerebral cortex. There are also neurofibrillar degeneration and nuclear alterations affecting the chromatin material. In addition to these cellular changes, Courville[1] described multiple focal lesions characterized by areas of cell loss, either in the cerebral cortex or the nuclear masses of the brain stem, which appear to be the result of anoxia, incidental ischemia due to vasospasm, or a prolonged drop in blood pressure due to primary shock of concussion or subsequent traumatic shock. In addition to these direct cellular and structural alterations, the author described a third change incidental to edema of the brain. This is manifested histologically by acute swelling of the oligodendroglia and increased vacuolization of the choroidal and ependymal epithelium as a consequence of the cerebral edema. It also is evident that there is a decided disturbance of the vasomotor regulatory mechanism as reflected by such symptoms as postural syncope and vertigo. It follows then that the postconcussion syndrome is due to an organic lesion rather than a functional disorder in a neurotic person.

In consideration of these neuropathologic changes in the postconcussion syndrome, it occurred to the writer that carbon dioxide inhalations, which had been used by Meduna[4] and others in the attempted treatment of neurotic conditions, might be of value.

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

Carbon dioxide therapy was introduced by Meduna[4] in 1948 for the treatment of neuroses. He based his rationale primarily on Lorente de Nó's work on the isolated nerve. Lorente de Nó[5] showed that carbon dioxide, in significant concentration, raised the threshold of stimulation, increased the membrane potential, increased the ability of the nerve to conduct trains of impulses, and delayed the appearance of fatigue in the stimulated nerve. This author also demonstrated that the effect of the carbon dioxide on the membrane potential is proportionate to the logarithm of its concentration. Dusser de Barenne, McCulloch and Nims[6] found that the low pH of the cortex caused by carbon dioxide was associated with low electrical activity and a decreased excitability of the cortex. Meduna[4] extended this to include the Eccles-Brooks hypothesis[7] wherein the increase in membrane potential lowers the excitation of the Golgi cells and so converts many excitors into inhibitors, thus augmenting inhibition.

Other research has shown additional effects of carbon dioxide on nerve tissue. It is known from the work of McLennan and Elliott[8] that carbon dioxide destroys acetylcholine by lowering the pH in the brain. Moreover, Bain and Klein's work[9] indicates that the concentration of brain lactate and pyruvate bears an inverse relation to the levels of carbon dioxide, hydrogen and oxygen, in the cerebral blood. They thought that the "resulting increase in blood flow and oxygen tension (brought about by the 30% CO_2 and 70% O_2 mixture) enabled the brain to more clearly balance energy demands with oxidative processes and as a consequence less lactate was formed and high energy phosphate reservoirs were not depleted."

In addition to the effect of carbon dioxide on nerve tissue per se, its effect on cerebral blood flow has been clearly demonstrated. The works of Kety and Schmidt[10] and Scheinberg[11] have demonstrated that carbon dioxide is the most potent cerebral vasodilator there is, and that concentrations of carbon dioxide above 10 per cent produce profound increases in total cerebral blood flow. Hence, carbon dioxide produces a double-barreled effect wherein the high carbon dioxide tension effect on the cells is potentiated by an increased blood flow with increase in available oxygen as well as whatever beneficial effects may result from increased cerebral circulation. As a consequence, the chronic vasospasm described by Courville[1] could well be ameliorated. Consideration also should be given to the fact that arterial oxygen tension is increased by the treatment, and this may be of some therapeutic significance.[4]

In consideration of these effects of administration of carbon dioxide—oxygen inhalations, it was believed that this treatment method would provide a multi-edged weapon in the correction of the underlying cellular and vasomotor changes in the postconcussion syndrome.

Procedure

One hundred per cent carbon dioxide and 100 per cent oxygen in separate tanks are supplied and mixed through a Y tube so that the concentrations of each gas can be modified. The patient, after preliminary instructions as to what he would expect to feel, is given 100 per cent oxygen for a few breaths until he adjusts to the mask and inhalations. Then about 5 per cent carbon dioxide is added to the mixture to permit the patient to adjust to the odor of the gas. After a few whiffs, the carbon dioxide concentration is increased gradually until there is a 50 per cent oxygen and a 50 per cent carbon dioxide mixture given at about 8 to 10 liters per minute from each tank. This results in a profound hyperpnea, and within 10 to 20 inhalations the patient usually lapses into coma. This is considered the end point of the treatment. The mask is removed, and the patient is allowed to recover spontaneously. Treatments are given three to five times weekly. It is to be noted that this method of treatment differs from the methods of Meduna[4] and LaVerne[12] in that the former uses a 30-70 per cent mixture and the latter a rapid coma technic using 100 per cent carbon dioxide in one or two inhalations. It is believed that the method described in this paper results in less anxiety in the patient since unconsciousness is reached rapidly and permits continuation of the treatment. This is an important consideration as many patients, if not properly handled, will dislike the treatment so much that they will discontinue it.

Results

A total of 136 patients, all suffering from a postconcussion syndrome, were treated by this method. Importantly, most of them were either receiving compensation or were currently involved in litigation in compensation or negligence suits because of accidents. This aspect is stressed since the economic factors of prolonged illness might be considered important to these patients and all

of them would gain secondarily by prolongation of their symptoms. Hence, improvement, if reported, would be considered significant. The number of treatments varied from seven to 69 with a median of 18 treatments (table 1).

Table 1. — Number of Carbon Dioxide Treatments

1-10	11-20	21-30	31-40	41-50	51-60	61-70
18	62	27	12	8	7	2

Some patients recovered in three weeks, and a few required as much as four months to recover.

Over-all quantitative evaluation of the therapeutic effects of carbon dioxide inhalations showed that of the 136 patients (Group C), 86 made a complete recovery, 34 showed improvement, 14 discontinued treatment, and only two patients were unimproved. This results in a complete recovery rate of 63 per cent (table 2) or, of those taking the treatment fully, 70 per cent recovered and 98 per cent improved.

50 months prior to beginning carbon dioxide inhalations. It is of significance to note that of these 52 patients with their long-standing symptomatology, 32 completely recovered, 18 improved and only two showed no improvement. With this group a median number of 22 treatments was administered (table 2). Since this group of patients had been ill six months or longer, they might be considered as a control group for they had not responded to other forms of treatment. They showed a recovery rate of 61 per cent, which compares favorably with the recovery rate of 63 per cent for the group as a whole and with the recovery rate of 74 per cent for the group which had been ill for a period of less than six months (table 2).

It follows then that the definite amelioration of symptoms, after the other forms of treatment had been unsuccessfully attempted, could be attributed to the specific effect of carbon dioxide–oxygen therapy. These other forms of treatment included physical therapy, traction, passage of time, analgesics, sedatives and psychotherapy.

Table 2. — Results of Carbon Dioxide Treatments

Group	Number	Median Number of Treatments	Recovered	Improved	Unimproved	Recovery Rate	Improvement Rate
A	84	19	62	22	0	74%	100%
B	52	22	32	18	2	61%	96%
C	136	18	86	34	2	63%	88%

The fourteen patients who discontinued therapy before complete recovery was attained all showed some improvement.

Since, in the private practice situation, one cannot utilize control studies, such as comparing the effect of nonspecific (placebo) treatment, an attempt at such comparison was made by giving consideration to the effectiveness of treatment in terms of the duration of symptoms, since the patients with a chronic condition had been treated under various regimens without apparent amelioration of their symptoms. Eighty-four of the 136 patients had been suffering from a postconcussion syndrome for a period of less than six months before beginning carbon dioxide inhalations. In this group (Group A), after a median number of 19 treatments, 62 patients made a complete recovery, and 22 were improved. The complete recovery rate was 74 per cent, and the improvement rate was 100 per cent.

Fifty-two of the 136 patients had been suffering from the effects of their injury for from six to

Although the difference in recovery rates between groups A and B (before and after six months) is not significant at the 0.05 level (Chi Square = 3.37), there is a trend to indicate the treatments are more effective when started earlier in the disease.

Improvement was initially noted by a decrease in the intensity and frequency of headaches followed by a decrease in nervousness and irritability. The following case histories are illustrative.

Report of Cases

Case 1.—A white man, aged 48, was first seen on Feb. 21, 1957. He reported that he was involved in a head-on automobile collision on Oct. 22, 1955. He was struck on the head and face and was unconscious for an undetermined period of time, regaining consciousness while in the ambulance en route to the hospital, and then lapsing back into unconsciousness again. On regaining consciousness he was dazed and confused for several minutes thereafter. He suffered fractures of the nose and cheeks. Plastic surgery was performed, and he was under the care of a neurosurgeon. Apparently, serial electroencephalograms were made, which showed progressive clearing of abnormalities.

Since the accident, he had been having frontal occipital headaches, aggravated by exertion. At times he was slightly confused, especially when he became irritable.

He slept poorly, but his appetite had been good. He noticed that he was constantly fatigued and had occasional bouts of nausea and dizziness, with some blurring of vision on prolonged reading. He complained of impairment of memory and postural syncope. Psychiatric examination failed to reveal any evidence of psychosis or neurosis. His past history was not remarkable and revealed a good socioeconomic adjustment. Neurologic examination was essentially within normal limits.

Beginning on March 25, 1957, the patient received carbon dioxide inhalations three times a week and after the first week began to show initial improvement. After 20 treatments, he was virtually asymptomatic. He was discharged on May 7, after a total of 29 treatments, as completely recovered. His case was closed with the insurance carrier without litigation.

Case 2.—A 51 year old white man was seen on March 27, 1956, having been referred by his attorney. The patient reported that on January 6 his stationary car was struck violently from the rear and he was pinned between the wheel and the seat. His head was knocked forcibly backwards, and he was rendered unconscious for about 15 to 20 minutes. On regaining consciousness, he was confused and disoriented for a short period. He was taken to St. Francis Hospital, where he was kept for five days and then sent home. He did not improve, and on February 6 returned to the hospital for another six days of traction.

Since the accident he had been complaining of postural syncope, mild headaches, and blurring of vision, with difficulty in focusing. He did not complain of nervousness. He stated, however, that he was irritable, lacked patience, and flew off the handle easily. He had an impairment of memory for recent events, lacked energy and tired easily with minimal exertion. He had some occasional pain in the back of his neck. Psychiatric examination failed to reveal any evidence of psychosis, neurosis, or significant personality disorder. The neurologic examination was essentially within normal limits, except for some mild spasm of the cervical musculature, bilaterally.

The patient was given carbon dioxide inhalations approximately three times a week and he showed progressive improvement, with diminution of headaches and irritability. Treatments were discontinued on May 14, when he had received a total of 19 treatments, because an acute sinusitis developed. He returned on June 21, stating that he had had a return of the symptoms since discontinuing treatment; so treatment was resumed. He received 14 more treatments after which he was completely asymptomatic. He was discharged as recovered on July 30. His case was settled out of court the following September, and he had had no recurrence of symptoms up to that time.

Discussion

It is believed that the carbon dioxide—oxygen inhalations were effective because the increased carbon dioxide tension decreased the irritability of presumably damaged nerve cells, increased the oxygen tension, and increased cerebral blood flow, all of which could lead to healing and correction of the underlying dysfunction.[1] Whatever beneficial effects that might accrue from transient increased arterial oxygen tension should also be considered.

These beneficial effects are in conformity with the concepts of the neuropathology of the postconcussion syndrome wherein there is damage and irritability to nerve cells; focal ischemia due to vasospasm, and vasomotor instability. Consideration might be given to the notion held by some that the postconcussion syndrome is really a neurosis and may be benefited by carbon dioxide as other neuroses are.[13] It is thought that such a tenet has been disproved by Courville[1] and certainly the rate of improvement is significantly greater than that claimed in the treatment of anxiety neuroses. A present study is under way correlating the response to treatment with the frequency and severity of neurotic signs as shown in the clinical examination and Rorschach testing. This study will also compare the psychologic makeup of those individuals in whom a postconcussion syndrome develops after a brain concussion with those in whom it does not develop.

Summary

One hundred and thirty-six patients, all suffering from a postconcussion syndrome, were treated by carbon dioxide–oxygen inhalations. Following a median number of 18 treatments, 86 patients made a complete recovery in that they were asymptomatic, 34 showed improvement, and only two were unimproved. A complete recovery rate of 63 per cent was obtained, with a combined recovery and improvement rate of 88 per cent. Discounting those who discontinued treatment, the over-all improvement rate was 98 per cent.

It is presumed that physiologic and cellular changes occurred in either the cerebral cortex or nuclear masses of the brain stem, or in both, as a consequence of brain concussion, these changes resulting in the subjective complaints known as postconcussion syndrome.

It is hypothesized that the carbon dioxide–oxygen inhalations decreased the irritability of the presumably damaged nerve cells by increasing the carbon dioxide tension, increasing the oxygen tension and increasing the cerebral blood flow. Presumably, correction of the underlying dysfunction and healing occurred.

It is suggested that this clinical report might provide a reference and stimulus point for further studies in which more rigid experimental control could be obtained.

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Emotions and Epinephrine-Norepinephrine Metabolism

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Since the days of Cannon,[1] the importance of epinephrine and norepinephrine metabolism in relation to psychiatric phenomena has been well recognized. Because of a lack of knowledge of amine metabolism, and because of the great difficulties in obtaining quantitative determinations of these substances, it was long impossible to provide any detailed verification and expansion of Cannon's initial hypotheses. In recent years, however, biochemical advances have made it possible to make quantitative evaluations of epinephrine and norepinephrine in blood and in urine. As a result of these advances, many aspects of the relationship between these amines and the clinical phenomena of illness have been explored.

Using the methods of Weil-Malherbe and Lund, many investigators have concentrated on one aspect of these relationships, the connection between levels of emotion and levels of circulating epinephrine and norepinephrine.[2] Such investigations, at the Payne Whitney Psychiatric Clinic, have involved repeated testing of 114 hospitalized patients, over the past three years. This body of information allows for a tentative formulation of the factors which influence the emotion-amine relationship, and will provide the major basis for the following discussion.

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Read before the Florida Psychiatric Society, Bal Harbour, May 10, 1958.

Patterns of Emotion-Amine Correlation

General Correlation.—A statistical analysis of the results with the 114 patients described makes it clear that no simple correlation between clinical state of a patient and levels of amines is possible. It was found that the mean level of circulating plasma epinephrine in the patient group was 1.3 micrograms per liter, and that the mean level of circulating plasma norepinephrine was 3.3 micrograms per liter. This level was not significantly different from the quality of circulating epinephrine and norepineprine found in a group of nonhospitalized, "normal" persons. Neither was there any significant deviation from this mean when subgroups of patients were compared, in terms of diagnosis, duration of illness, or degree of behavioral disturbance.

It was found, instead, that individual patients vary greatly in their levels of circulating epinephrine and norepinephrine from day to day, and that these variations in the level of circulating amines provided a clue to parallel variations in their state of emotional disturbance. Patients' varying emotional status was measured, at repeated intervals, on a rating scale, which provided for a quantitative measurement of their observable levels of anxiety, tension, resentment, and depression. When changes on this rating scale were compared with changes in the quantitative levels of the circulating epinephrine and norepinephrine, a general correlation became apparent. In 63 per

cent of instances, it was found that epinephrine and norepinephrine fluctuated in accordance with the emotional state of the individual patient. Levels of amines rose when the subject became more disturbed emotionally, and fell when he became less disturbed emotionally.

Beginning with this 63 per cent correlation, an analysis was made of the difference between the patients who showed a correlation and the patients who did not show a correlation. It was possible to isolate a number of factors which serve to distinguish those patients who showed a positive correlation and those patients who did not. When these factors are combined with factors described by other workers, it becomes possible to discern a regular pattern in the relationship between emotions and epinephrine-norepinephrine.

The pattern which emerges fortifies the notion that there is a basic tendency, in each person, for the emotions and the epinephrine and norepinephrine to fluctuate in parallel fashion, as has been described. It appears, however, that this parallel fluctuation appears clearly only when characteristics of illness, personality, and activity are optimal. The conditions which favor the appearance of the parallel relationship are of two sorts, (a) factors generally favoring a parallel relationship, and (b) factors which determine whether epinephrine or norepinephrine is the better indicator in the parallel relationship.

Factors Generally Favoring a Parallel Relationship.—The first of the factors favoring the parallel relationship between amines and emotion is that of diagnosis. In patients with certain types of illness—depressive reactions in middle or late life, chronic schizophrenic reactions, chronic psychoneurotic reactions, paranoid reactions—a reliable parallel between emotions and amine level was found to exist. It is worthy of note that all of the illnesses described are characterized by their relatively high stability. In contrast, no correlation exists between emotions and amines in the presence of illnesses characterized by chaotic changes in behavior, and by personality disruption of considerable degree — acute schizophrenic illnesses, panic reactions, manic excitements. It would appear necessary, therefore, that a relatively clearcut illness exist in the patient under study before reliance can be placed on levels of epinephrine and norepinephrine as indicators of emotional change.

The second factor influencing the reliability of the emotion-amine relationship is a psychopathologic one. Even in the stable illnesses described, the parallel relationship between emotions and amines is disrupted if dissociative phenomena, such as hysterical symptoms or phobic symptoms, are present. If these symptoms are present in the patient's symptomatology, a parallel relationship between emotions and amines can only rarely be found. Indeed, there is a strong suggestion that, when these phenomena are present, the amines tend to fall into an inverse relationship with the strength of the symptoms, falling when the dissociation is strongest, and rising when the dissociation becomes less severe.

Factors Determining Whether Epinephrine or Norepinephrine Will Be the Primary Indicator of Emotional Change.—With the conditions of illness as described, one may expect to find levels of circulating amines paralleling changes in the emotional status of the patient. Almost invariably, however, it is found that one of the amines provides a more consistent indicator of emotional change than does the other amine. Whether it is epinephrine or norepinephrine that will provide the indication appears to be a function of the personality of the patient, and the pattern of activity in which he is engaged.

The fact that the patient's personality will determine whether he reacts to stress with epinephrine or norepinephrine has been formulated by Funkenstein, King and Drolette.[3] They described three such determining personality types—anger-in, anger-out, and anxiety. By using a modification of this personality evaluation technic, it can be found that these personality categories also indicate whether or not emotional change is paralleled by one or the other of the amines. Thus, patients who may be characterized as "anger-in" or "anger-out" will have the highest correlation existing in the parallel relationship between their emotional states and their norepinephrine levels. Conversely, patients who are characterized as "anger-in" or "anxiety" will be found to have the highest degree of correlation existing in the parallel between their emotional states and their levels of norepinephrine. This finding does not preclude the fact that both amines may, in the individual patient, parallel the emotions; it merely indicates that one or the other is the more reliable under specific situations of personality structure.

Another important factor determining whether changes in emotions are paralleled by changes in

levels of epinephrine or norepinephrine is the activity of the patient. Elmadjian and Hope,[4] working with urinary amines, have studied different persons in stressful situations. If, under stress, a person can be active—like the prize fighter or the hockey player—his norepinephrine level will rise much higher than will his epinephrine level. If, under stress, the person cannot take action—like the hockey coach, or the patient presented at a staff conference—it will be the epinephrine that gives the more pronounced response. The greater the activity, therefore, the greater the likelihood that norepinephrine is the key amine; the less the activity, the greater the likelihood that epinephrine is the key amine.

Types of Patterns in the Relationship Between Emotions, Epinephrine and Norepinephrine.—As a result of the factors previously described, it is possible to differentiate three types of relationship between the emotions and the amines. These three types are as follows:

1. Parallel relationship between emotions and epinephrine or norepinephrine. In patients with depressive reactions, chronic schizophrenic reactions, chronic psychoneuroses, and paranoid states, a parallel relationship exists between the emotions and the amines. Within these situations, the parallel relationship will be reliable, provided dissociative phenomena are not present. The parallel relationship will be found most prominently in one or the other of the amines, depending on the personality type.

2. Unstable relationship between emotions and epinephrine or norepinephrine. This type of relationship is found in patients with acute schizophrenic reactions, panic reactions, and manic excitements. Possibly due to the chaotic nature of the illness, or to the great fluctuations in activity which are present in these illnesses, the emotions parallel the amines on some occasions, but bear no relationship to amines on other occasions. At the present time, no reliance can be placed on levels of the circulating amines as indicators of emotional change, within these conditions.

3. Epinephrine and norepinephrine levels forming an inverse relationship with intensity of dissociative symptoms. This type of relationship appears in only a small percentage of the total number of patients. The inverse relationship is clear only within the diagnostic categories described herein, when these illnesses are associated with pronounced dissociative features. When such conditions are met, it will be found that epinephrine and norepinephrine tend to be low when the dissociative phenomena are high, and to rise when the dissociative levels fall. The change in the levels of dissociation may come about as a result of psychotherapeutic measures, or physical treatments. Almost invariably, when dissociative features are dominant in an illness, they seem to assume a stronger relationship with amine levels than do the emotions.

Discussion

It appears that the advances which have been made in delineating the relationship between emotions, epinephrine and norepinephrine are approaching the point at which these physiologic measurements may begin to have clinical usefulness. Certainly, within certain diagnostic categories, the changes in levels of circulating epinephrine and norepinephrine seem to be reliable indicators of changes in the emotional state of the individual patient. It must be observed, however, that the biochemical procedures which are necessary to determine levels of epinephrine and norepinephrine are highly involved, and require a research laboratory for their execution. Furthermore, the nature of the personality and psychopathologic variables which influence this relationship are not yet fully clarified. It may be hoped, however, that the next few years will see sufficient advances, both in the laboratory and in clinical evaluation, to enable the clinician to have available a new tool. The value of this new tool cannot be underestimated; to be able to apply quantitative criteria to the levels of emotions existing in a patient will be of inestimable value in research, and in psychiatric treatment.

A second aspect of the relationship between emotions and amines also seems worthy of consideration. Epinephrine and norepinephrine certainly have an objective importance based on their own prominence and on their widespread effect within the body. They assume even more significance when they are recognized as key members of an important group of chemical substances. This group of chemical substances has recently been reviewed by Himwich,[5] and is indeed an impressive one. Numbered among the substances which are chemically related to epinephrine and norepinephrine are importanct psychotomimetics, stimulants, and metabolites—mescaline, adrenochrome, bufotenin, lysergic acid diethylamide (LSD), amphetamine, serotonin, and histamine, to name only a few. These chemically related

substances, in turn, link epinephrine and norepinephrine to the major psychopharmacologic agents; thus, chlorpromazine is an antihistaminic, reserpine depletes the body stores of serotonin, and iproniazid interferes with the amine oxidase system. Viewed in this fashion, it is clear that epinephrine and norepinephrine are the most prominent members of a chemical family which includes most of the major psychotomimetics, tranquilizers, and stimulants. As such, they have an importance far beyond their individual importance simply as chemical substances.

When epinephrine and norepinephrine are seen in this fashion—as particularly crucial units in a widespread system—it becomes clear why the study of these substances is so important and so difficult. It also puts a greater perspective on the value in pursuing the findings indicated in this paper. Beyond any possible clinical application, a clarification of the relationship between emotions and amines offers one of the best opportunities to forge a link between an observable clinical phenomenon—emotion—and substances which are operating at the core of central nervous system metabolism. Through understanding the workings of these members of the important family of amines, it is possible that investigators may be in the process of achieving a better understanding of the workings of the whole family. The advances of the last few years indicate that this is a good possibility.

Summary

Within certain diagnostic categories—depressive reactions, chronic schizophrenic reactions, paranoid states, chronic psychoneurotic reactions—changes in circulating epinephrine and norepinephrine levels show a parallel relationship with changes in the emotional state of patients.

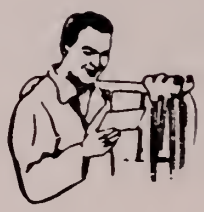
Depending on the nature of the patient's personality, and on the activity pattern which he displays, either epinephrine or norepinephrine may have the more pronounced relationship.

These relationships offer significant leads for clinical testing and for research in the future.

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Cerebral Hemispherectomy In Infantile Encephalopathy

Indications for and Results of With Report of a Case

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The surgical extirpation of epileptogenic foci in the brain is a well known method of treating certain medically unmanageable convulsive patients.[1] In 1938, McKenzie, cited by Williams and Scott,[2] performed a cerebral hemispherectomy in an attempt to control convulsive seizures. In 1950, Krynauw[3] reported a series of 12 patients upon whom he had performed hemispherectomy. He treated these patients primarily because of uncontrolled convulsions. In the group, however, there were several who had had such severe personality disturbances that they had to be forcibly excluded from society. In 1955, French, Johnson, Brown and Van Bergen[4] reported on nine hemispherectomized patients who were so treated for "control of intractable convulsive seizures." McKissock[5] reported a series of 18 patients with infantile hemiplegia upon whom he performed hemispherectomy. There were 11 patients in the series reported by Gros and Vlahovitch[6] in 1955 and 10 in the series of Ferey[7] reported in 1956. These series are comprised of patients with "infantile encephalopathy" with hemiparesis or hemiplegia, seizures and personality problems. They were brought to surgery primarily because their seizures were not controlled with anticonvulsant medications.

From these studies certain indications for cerebral hemispherectomy in infantile encephalopathy have been drawn:

A. Severe convulsive disorder uncontrolled by adequate anticonvulsant medication
B. Severe personality disturbance

It must be emphasized that this procedure is undertaken only in those patients who have had the brain damage from infancy.

The results of hemispherectomy in these patients have been:

A. Between 70 and 80 per cent of the patients derive great benefit in that their seizures are eliminated or are controlled with reduced medication.
B. About the same number or more have had dramatic improvement in the realm of personality adjustment. Indeed, Ferey[7] stated that "severe character difficulties in themselves in infantile hemiplegics can be sufficient indication for hemispherectomy."
C. Because of A and B, many patients are benefited in their ability to learn.

From the University of Miami School of Medicine, Miami.

Report of Case

An 18 year old boy, kindly referred by Dr. Peritz Scheinberg, was noted at birth to have a port-wine stain



Figure 1.



Figure 2.

over the right side of the forehead and upper right side of the face, the Sturge-Weber syndrome. Generalized seizures began at the age of three months. Jacksonian seizures involving the extremities on the left side began at about the age of six months. Petit mal was noted later. In 1953 the parents were told that "excision of the abnormal brain offered the only possible hope." He had been seen at other clinics, and various medications had been tried, but in spite of them he was having at least two or three left-sided Jacksonian seizures and at least 20 petit mal seizures a day. Generalized seizures occurred several times a week, oftentimes in series. His behavior was probably even more serious a problem than his seizures. By 1956 he could no longer be managed at home. He was unreasonable, spat at and bit people, wandered out of the house at night and was beset with violent temper tantrums. It became necessary to "institutionalize" him.

On examination in September of 1956, he was obviously mentally retarded, withdrawn and antagonistic when disturbed. There was the previously noted port-wine stain over the right upper portion of the face and forehead (fig. 1). There were left spastic hemiparesis, corresponding hyperreflexia and abnormal reflexes. The left-sided extremities were smaller and less well developed than those on the right. Cortical sensory modalities were thought to be adversely affected on the left.

Roentgenograms of the skull showed mild asymmetry of the cranial vault with mild retardation in development of the right half of the skull. There was extensive calcification of almost the entire surface of the right cerebral hemisphere, corresponding to the gyri (fig. 2.)

Electroencephalography showed total disorganization of the pattern on the right side with interruption of the pattern on the left by numerous bursts of abnormal waves (fig. 3).

Right-sided arteriography was performed, but no abnormality of cerebral circulation could be made out.

On October 23, right-sided hemispherectomy, sparing the caudate nucleus and the thalamus, was accomplished by one of us (I. P.).

Figure 4 shows the surgical specimen. The report of the pathologist described the specimen to be a "right cerebral hemisphere consisting of cortex and white matter" and microscopically: "The striking feature is a diffuse calcification, mainly located in the outer layer of the cortex but also in isolated form elsewhere and around intracerebral blood vessels especially in the subcortical white matter. There is a diffuse loss of nerve cells, while many of the remaining ones show chronic degenerative changes."

After an uneventful recovery the patient was discharged from the hospital on November 16.

Postoperative roentgenograms showed the position and extent of the bone flap and the persistence of a small area of calcification in the region of the thalamus (fig. 5).

Electroencephalography showed remarkable change. The left-sided pattern was reflected to the right side with a decrement in amplitude. The record shows pronounced improvement (fig. 6).

The patient has been followed regularly and when last seen on Jan. 19, 1958, he was alert, friendly, cooperative

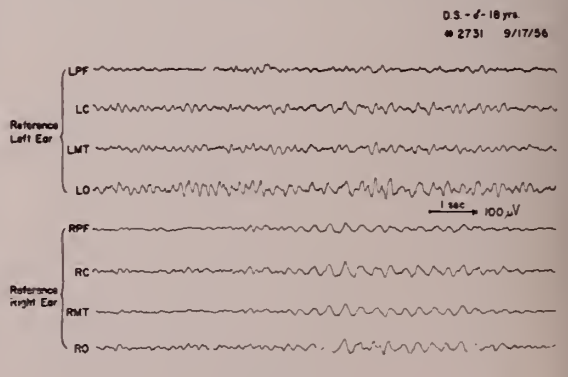


Figure 3.



Figure 4.

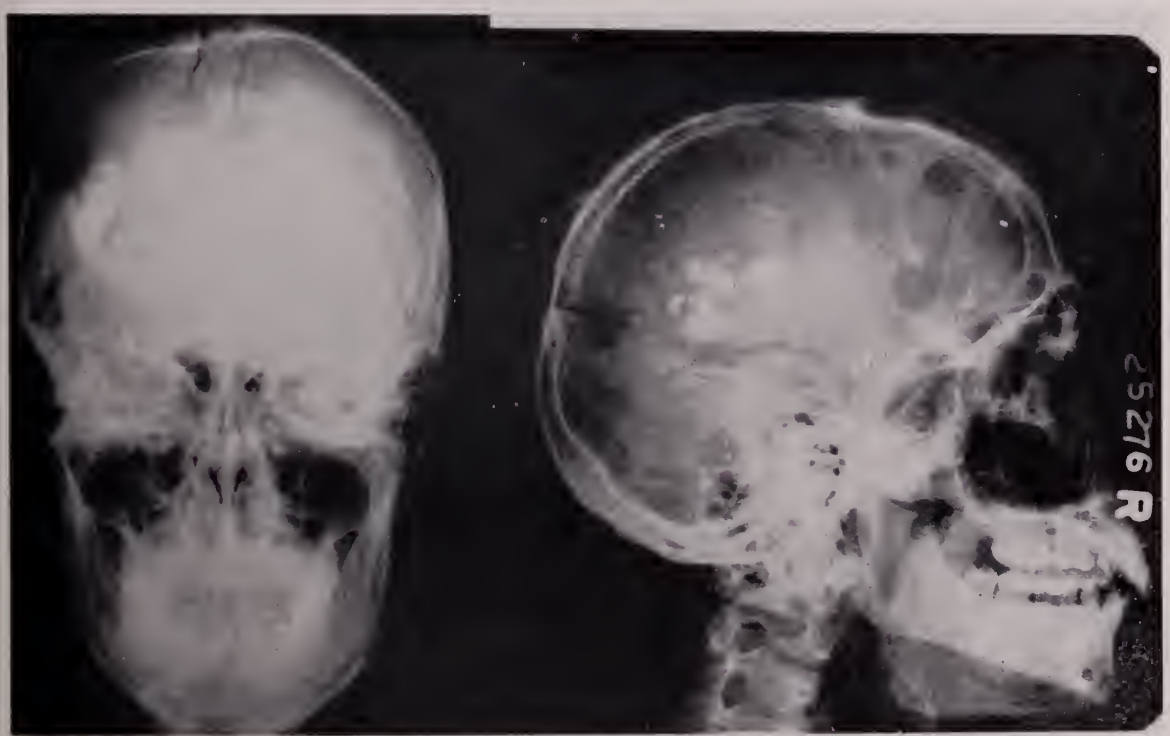


Figure 5.

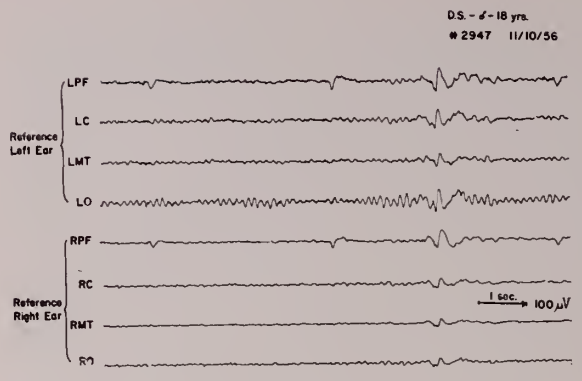


Figure 6.

and oriented. The spastic left hemiparesis is as previously. A left visual field defect, suspected preoperatively, is definite now. According to his father "his behavior and personality have improved to such a great extent that my wife and I think we have another boy and that he is not the old D. that we knew. He helps his mother around the house and wants to learn. He spends Saturdays with his grandmother in another city. They usually go out to a restaurant for lunch and then to a movie. He is sweet and friendly."

He is still taking anticonvulsant medication, but has gone as long as five months without any type of seizure.

Discussion

Malfunctioning cerebral tissue demonstrates itself not only in the weaknesses, sensory difficulties and related signs and symptoms commonly associated with brain damage, but also to the detriment of the organism as a whole by:

1. Originating or reflecting abnormal electrical activity resulting in one or another type of convulsive disorder
2. Adversely affecting the personality as a whole (in association with 1)

The removal of such diseased cerebrum therefore contributes constructively to the problem of seizure control and personality adjustment.

To excise such tissue is akin to removing a dragging anchor. The physical functioning of such patients after surgery may be slightly altered by changing a spastic weakness to a more flaccid one, but electrical function and personality are often dramatically affected favorably.

Summary

Cerebral hemispherectomy in infantile hemiplegics with unmanageable convulsions and/or severe personality disorder has become a well recognized procedure. Its indications and results are briefly described.

A case is reported in which a patient with the Sturge-Weber syndrone, infantile hemiplegia, unmanageable convulsions and severe personality disorder was subjected to cerebral hemispherectomy with improvement.

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The Changing Role of the Radiologist

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The specialty of Radiology has passed through a number of metamorphoses since the date of its inception over 60 years ago. It is noteworthy in passing that the original radiologists were nonmedical men such as physicists, electrical engineers, pharmacists and photographers. The original x-ray therapists were also nonmedical men who were hooted and abused because they suggested and attempted to treat carcinoma by other means than the knife.[1] The original x-ray departments were obscure unused corners of basements or under-the-stairs storage places. It is to the eternal credit of these lay pioneers that they undertook the study of medicine at mature ages in order to improve the quality of their work.

The purpose of this article is not to bemoan the lot of the radiologist but to draw attention to his changing position in the modern medical pattern. Soon after the specialty of Radiology became firmly established, a wave of radiologic optimism swept the medical profession. Patients were referred for diagnosis and therapy of the most obscure and varied complaints. The early radiographer gradually became a radiologist. In fact, he was considered somewhat of a medical oracle. The radiologist was the medical glamour boy of his day. Among these men, unfortunately, were numerous medical martyrs who lost their fingers, hands, arms and eventually their lives learning the dangers of unshielded radiation. In this heyday, the x-ray department was the focal point of the hospital where the staff met to discuss problems of diagnosis and therapy.

Changes in Diagnostic Radiology

The first change in the status of the radiologist began with the high pressure sale of x-ray diagnostic equipment to newer graduates as a practice builder. Many unqualified and some unprincipled men began to exploit fluoroscopy and roentgenology because of their novelty. Then arose the practice of bringing films for interpretation to the radiologist. This practice disregarded the fundamental premise that the radiologist was primarily a clinician and that an x-ray film did not per se constitute a radiologic consultation. One must not forget that the radiologist is entitled to a clinical history and, if necessary, a physical examination of the patient. Needless to say, this practice of "ghost radiology" tended to lower the status of Radiology as a specialty.

The rise of specialization was the major cause of the changing role of the radiologist. Radiologic diagnosis was taught as an essential portion of the training of practically every specialty. As a result, many of the newer trained specialists were well versed in x-ray interpretation in their own fields. Many worth while contributions to the radiologic literature have been made by these men. Unfortunately, they see the patient from their own narrow radiologic standpoint. It is somewhat humiliating to the radiologist, if not ungentlemanly on the part of such specialists, to see many of them practically bypass the radiologist when they seek the services of the x-ray department. This attitude has caused a loss in stature of the radiologist in the mind of the general practitioner. Gradually in my own time, I have seen the radiologist relegated to the role of a general practitioner of radiology.

Changing Trends in Therapeutic Radiology

In the field of x-ray, radium and isotope therapy I have also noted changing trends. With the recognition of the cumulative deleterious effects of radiation, the treatment of benign conditions by radiation has been sharply curtailed. Prolonged therapy of benign conditions by radiation should, of course, be condemned. On the other hand, in few cases of malignant disease is the patient referred for treatment when curative therapy can be given. As a result of treating for palliation, the status of radiation therapy has been further depressed. With the advent of nuclear medicine, there has been a regrettable scramble among the specialties regarding to whom this branch rightfully belongs. The internist, the endocrinologist and the pathologist each has asserted, and with good arguments, that isotope therapy belongs to his field. Since one is dealing with forms of radiation which the radiologist has painfully learned to respect over a period of 60 years, it would seem that the radiologist has earned the right to use this modality.

There has been a regrettable lack of liaison between the gynecologist and the radiologist, to the detriment of both. The entire science of radiation dosimetry was developed by the close association of physicists and radiologists. The new radiologist, who comes from his residency highly versed in radium therapy, soon loses his skill from a lack of practice. The gynecologist who uses radium in a stereotyped manner loses the value of skilled assistance which is close at hand.

Insurance Problems

The Blue Cross plans, since their inception, have bypassed the rights of the radiologist. They have claimed that Radiology is a part of hospital service and that if the radiologist claims a fee for his service, it should come out of the daily hospital allowance. If, as in some instances, the radiologist has had the temerity to bill a Blue Cross patient for his services, this act has threatened to remove the hospital involved from the approved list. Sadly enough, the attorney general of the great State of New York has ruled that Radiology does not constitute the practice of medicine. This ruling was no doubt influenced by the insurance and hospital lobby in Albany. There have been a number of court battles to prove that Radiology constitutes the practice of medicine and that it cannot be included as a hospital service.

Our own Blue Shield plans have also practically bypassed the radiologist. At first the radiologist was completely ignored. The Florida Blue Shield permits a limited diagnostic study if made within 24 hours after an accident. There is also a limited fee for x-ray therapy of malignant conditions. This provision results in a constant wrangling with Blue Shield patients as to how much radiologic service they can have without something coming out of their own pockets. To add insult to injury, many commercial insurance contracts stipulate that diagnostic x-ray work will be paid for only if performed in a hospital. This stipulation casts aspersions on the integrity of the radiologist and helps keep hospital beds filled with ambulatory patients.

Increased Cost of Equipment

In former years the young radiologist was usually taken into the office of an older man and soon became a partner or branched out for himself. With the shrinking of the radiologist's sources of income and with the increase in cost and complexity of radiologic equipment, this type of practice is disappearing. Whereas an x-ray office could be set up in former years for about $10,000, it takes from $30,000 to $50,000 to set up a modern office. If the clamor for supervoltage therapy increases, the private practice of radiology will become a thing of the past. The cost of a cobalt unit varies from $25,000 to $75,000. The only way a young radiologist can get started is to form a partnership and pool capital or work for a large institution.

Role of the General Radiologist

In spite of this dark picture, the general radiologist has a definite niche in modern medicine. His role as a radiation officer is paramount. He must not only protect himself but his assistants, his community and his colleagues from harming themselves and their patients from excessive radiation. Too often, in his diagnostic zeal, the neurosurgeon keeps his bare hands in the line of direct radiation. The orthopedist is often tempted to reduce fractures under the fluoroscope. The general surgeon often has an uncontrollable urge to remove foreign bodies under fluoroscopic control. The gastroenterologist has an understandable desire to check the healing of a duodenal ulcer every several weeks. The anxious parent will want a recheck on the progress of Perthes' disease, too often with deleterious effects on the gonads of a growing child. The patient who wanders from clinic to clinic and from doctor to doctor seeking x-ray diagnosis must be protected from excessive radiation. Someone must keep a radiologically level head when those about him are losing theirs.

The general radiologist must utilize all the modalities of protection at his command such as periodic blood counts, film badge service and similar monitor checks as well as constant checks on x-ray equipment and protective devices. Aprons and gloves may crack or disintegrate. Leaks may develop in doors and walls. He must teach his personnel and colleagues the value of distance as a prime source of protection. He must co-ordinate the x-ray findings of his specialist friends as well as his own. He can prove the value of x-ray therapy by exhibiting an interest in preoperative and postoperative findings as well as in autopsy reports. He must improve the quality of this work by personally seeing as many patients as possible to prove that he is a clinician and not a paraphotographer. He must personally see that patients are properly shielded from unnecessary radiation by the judicious use of cones and pro-

tective lead rubber devices. He must teach his colleagues as well as the laity that when it is properly used, the good from radiology outweighs any theoretic harmful effects.

The world is entering a new era of radiation. The atomic age ushered in new responsibilities for which the radiologist's training especially suited him. The invisible radiation and its effects were not new to him. The state and federal governments are becoming keenly radiation-conscious. A few states have outlawed the use of fluoroscopic shoe-fitting devices. The Board of Health of the City of New York has passed a ruling which will make it mandatory that all machines which produce ionizing radiation must be registered. The owner is responsible for the proper construction of such equipment and for the proper shielding of the surrounding walls. As the profession and public become more radiation conscious, it will be the general radiologist's responsibility to see that the environment is safe from the radiologic standpoint.

Radiologist's Future Role

The radiologist will continue to fill the need of a consultant in x-ray construction, technic and interpretation. It has been truly said that proper technic constitutes half the diagnosis. The specialist friends must be warned that pitfalls in diagnosis await those who ignore exact technics, variations in equipment and idiosyncrasies of personnel. He has complete mastery in the field of x-ray therapy, but he must continually prove its value in curative as well as in palliative spheres. He must earn the trust of the medical profession by maintaining a keen clinical sense. It has unfortunately become the habit of the chairman of most clinicopathologic conferences to bypass the clinical opinion of the radiologist on the assumption that he is not supposed to engage in clinical discussions. The fault is partly on both sides. Many radiologists rarely see the patients whose films they are interpreting. The patient may only be a shadow in the viewing room, but there is also substance.

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Alcoholism as a Public Health Problem

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Prominently identified with health advances in the nation have been public health programs. Notable accomplishments have been reported in the treatment and prevention of communicable diseases, the illnesses of childhood, and conditions which result from improper sanitation. Current studies and methods of control as applied to polio, cancer, cardiac conditions and arthritis are conducted in universities and medical centers, and currently prominent are the comprehensive programs designed to reduce the incidence of mental illness.

Alcoholism Defined

Bidding for increased attention of public health services during the last 20 years is the problem of alcoholism. Described as a type of addiction manifested by continued uncontrolled, excessive consumption of alcoholic beverages resulting in a pathologic dependency and broadly related to the personality of the individual drinker, this sociomedical condition is conservatively estimated to effect 100,000 residents of the State of Florida. As such, and to that extent, it constitutes a major disorder confronting public and private agencies as they are concerned with peoples' health and welfare.

It is significant to note that the Second Report of the World Health Organization Alcoholism Subcommittee in differentiating alcoholism from social drinking describes it as an addiction with a describable progression of symptoms.[1] They are charted as prealcoholic, prodromal, crucial, and chronic, and within each of these phases, symptoms are specifically listed.

There has been considerable discussion about the propriety or accuracy of the use of the term "disease" in relation to alcoholism as described. Obviously, the purpose in labeling alcoholism a disease or an illness or a medical condition or by any other term which places it squarely in the fields of public health and private medicine is the constructive intent to obtain the application of modern medical knowledge to the control and alleviation of the condition.

The use of any broad medical term in relation to alcoholism can be misleading unless the word is understood in its broadest sense to include mental as well as physical illnesses and psychologic as well as physical causes. There is at present no reliable evidence that alcoholism is a disease entity in the sense that it has a single specific cause such as vitamin deficiency, a hormone disturbance, a defective hereditary background, or an underlying neurosis, although these conditions may coexist in an alcoholic person with the excessive drinking. In fact, the great majority of therapists and researchers agree that the search for a single cause of alcoholism has been nonproductive. Multiple factors are always presented in clinical histories and, in one way or another, must be managed and treated if the condition is to be brought under control. The excessive drinking, uncontrolled or uncontrollable as it appears to be, is viewed as the chief symptom of alcoholism, and current approaches make it the point of initial attack while continuing therapeutic plans relate to underlying and associated conditions of various types, the totality of which is regarded as properly a medical problem.

Treatment

Modern treatment of alcoholism is a combination of established as well as experimental modes which integrate psychotherapy, psychiatric case work, psychologic tests, medical care and vocational rehabilitation, as these can be provided by specialized teams of professional people. There are also extremely encouraging reports from the use of group therapy.

The response to treatment by alcoholics varies greatly according to the level of alcoholism and the kind of person the patient is. Some segments of the alcoholic population will have a recovery rate as low as 15 per cent while others will have one as high as 80 per cent. The average is 40 per cent to 45 per cent.

Social studies state that alcoholism does not affect disproportionately most sections of a com-

Administrator, State of Florida Alcoholic Rehabilitation Program.
Read before the Florida Health Officers' Society, Bal Harbour, May 11, 1958.

munity or segments of a state's population. However a population may be classed or divided, it is conservatively estimated that one out of every 20 people who drink become addicted, and the alcoholic population consistently presents a cross section of the total population and social groups.

Causes

Search for the causes of alcoholism have deemphasized hereditary, biochemical and nutritional elements. The weight of the findings is now on the side of psychiatric factors with a new emphasis on social elements as these are incorporated into the character of individuals and then broadly related to or expressed in behavior.

It is currently reported by clinical services that the families of alcoholics are frequently and dynamically related to the continuance of addiction. Recent observations state that families may unintentionally contribute to the perpetuation of pathologic drinking and that many times treatment cannot be effective unless the nonalcoholic spouse is successfully involved in therapy as well as the alcoholic.

Florida Alcoholic Rehabilitation Program

Alcoholism in Florida has been made the special responsibility of the Florida Alcoholic Rehabilitation program. It was authorized by legislation enacted in June 1953, and is placed under the Board of Commissioners of State Institutions (Governor and Cabinet), the general state board which controls the activities of state mental hospitals, special schools and penal institutions.

While the Florida Alcoholic Rehabilitation Program is not exclusively, nor even in a major way, an institutional program, it was the wish of the sponsors of the legislation and the legislature that it be an independent, specialized agency, directly responsible to a general state board.

The statute creating the Program requires the Governor to appoint an Advisory Council of five members, three of whom are to be from a national organization interested in the problem of alcoholism, one of whom shall be a licensed medical doctor, and one of whom shall be a hospital administrator. While the law states that this Council is advisory only, it is, in effect, the governing body of the Program. By action of the Board, the Council has been directed to develop and supervise the Program.

The Alcoholic Rehabilitation Program combines treatment and rehabilitation (of which institutional care is a part), education and information, research and study. It brings together these types of activities into a single specialized service. The finances of the Program are derived from an allocated percentage of the Alcoholic Beverage Tax. This income is placed in a trust fund, and all expenditures for whatever purpose are made from it.

While research and study are a minor part of the Program's work, they are, nevertheless, vital. There are great gaps in both "pure" and "applied" scientific knowledge in relation to alcoholism. Present Program research, however, covers only study by the professional staff of admission criteria and the effectiveness of certain types of treatment.

Education and information are statewide activities. This phase of the Program, which has prevention and case finding as objectives, has developed sound activities and will expand. Present work includes distribution of printed materials, circulation of films, supplying speakers, holding of conferences, arranging of special inservice training courses, sponsoring special workshops-seminars and generally promoting professional training and education, as well as the dissemination of information to the general public.

The clinical services are supervised by a Clinical Director who is the general medical officer of the Program. These services include the Rehabilitation Center in Avon Park, with a capacity of 50 beds offering intensive psychotherapy for ambulatory men and women patients, and four outpatient clinics located in Jacksonville, Miami, Pensacola and Tampa. All units are headed by senior physicians who are psychiatrists, and staffed by the necessary personnel, such as internists, psychologists and psychiatric social workers. At the present time over 1,700 patients have been registered in all services. Fees are charged for care and rehabilitation in accordance with the person's ability to pay. People are not denied services because of lack of funds when they qualify for services in other ways.

Indefinite expansion of the Alcoholic Program's specialized services and activities is not anticipated nor considered desirable. While the prevalence of the problem will make additional services necessary as knowledge about alcoholism and experience with its treatment increases, it is expected that this need will occur only conser-

vatively in particular areas. It is hoped that by coordination of specialized activities with more general types, and that by demonstration of treatment as well as the spreading of information, the broader health and welfare services of all kinds will assign in their on-going work, as other conditions have been given, certain places which are appropriate to the size and complexity of the control and prevention of alcoholism.

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ABSTRACTS

The Clinical Laboratory as a Diagnostic Aid to the Ophthalmologist. By James N. Patterson, M.D. South. M. J. 51:970-976 (Aug.) 1958.

In this article a clinical pathologist outlines the many ways in which laboratory studies help the ophthalmologist in diagnosis and thus in treatment. He limits his discussion to studies relevant to the diagnosis of inflammatory ophthalmic conditions and especially to the hematologic aspects of diseases of the eye.

In inflammatory diseases of the external eye, the examination and culture of conjunctival exudates constitute the commonest diagnostic studies. By means of smears, one can usually make a general differential diagnosis between bacterial, allergic and viral conjunctivitis. In most bacterial infections, one must have cultures for precise identification of the organism. The material intended for diagnostic study should be obtained before any therapeutic agent has been given, and the exudate should be cultured on at least two different mediums, one of which must be a blood agar plate. By a simple laboratory procedure, the pathologist frequently can name the proper antibiotic to use in a given case even before identifying the actual causative organism. The increasing number of fungal infections of the eye and identification of the offending fungi are discussed, as are also the numerous laboratory diagnostic aids in various external ocular conditions.

Infections involving the inner structure of the eye are generally chronic and of a granulomatous nature. The diagnosis of these conditions, involving chiefly the uveal tract and less frequently the retina, depends for the most part upon immunologic phenomena secondary to tissue reactions. The relatively more common conditions in which these granulomatous lesions are found are tuberculosis, toxoplasmosis, sarcoidosis, histoplasmosis, blastomycosis, actinomycosis, syphilis and nematode infestation. The more important tests in the differential diagnosis of these diseases are reviewed. Also discussed are diagnostic tests called for by retinal changes that are frequently manifestations of systemic diseases, especially the metabolic ones, the commonest being diabetes mellitus. In addition, the role of the radioactive isotope tracer technic in the diagnosis of some ophthalmic conditions is evaluated.

The hematologic aspects of ophthalmologic importance are presented in some detail, including a review of the clotting mechanism. Of all the conditions which can be related to the hematopoietic system or circulating blood, hemorrhage is the most alarming, and spontaneous hemorrhage in or about the eye may be catastrophic to vision. To assist in determining the cause of hemorrhagic manifestations anywhere, and particularly in the ocular fundus, the pathologist performs a battery of tests, consisting of a complete blood count, sedimentation rate, hematocrit determination, bleeding time, Rumple-Leede tourniquet test, prothrombin time, protamine titration test, blood urea nitrogen and blood sugar level determinations, as well as total serum proteins. When indicated, other tests such as prothrombin consumption, thromboplastin generation test of Biggs and Douglas, serum electrophoretic pattern, hemoglobin electrophoretic studies, bone marrow examination, serum cholesterol, and total lipids are carried out.

The Carotid Body Tumor in Dogs. By Thomas M. Scotti, M.D. J. Am. Vet. M. Assn. 132:413-419 (May 15) 1958.

The purpose of this paper is to stimulate interest, particularly among veterinarians, in an infrequently reported neoplasm of dogs, the

carotid body tumor. This neoplasm appears in the neck in the vicinity of the branching of the common carotid artery. A canine carotid body tumor which was removed successfully at operation is described. Also presented is a brief discussion of the chemoreceptor system and of certain clinical and pathologic features of neoplasms of this system in man and in dogs, with particular emphasis on the carotid body tumor.

Complications of Middle Ear and Mastoid Disease Despite the Antibiotics. By G. Dekle Taylor, M.D. South. M. J. 51:1089-1100 (Sept.) 1958.

This study refutes the idea that antibiotics, as valuable as they have proved to be, will supplant the time-honored surgical principles in the management of middle ear and mastoid infections. A series of 86 cases of suppurative mastoid disease managed surgically during an eight year period is reported; 61 radical, 10 modified radical, 10 simple, and five revision mastoidectomies were performed. In half of the cases the onset of the disease occurred after the antibiotics became available, and in all cases sulfonamides or antibiotics were used in treatment at some time before operation. The disease process progressed despite these drugs, and surgical intervention was necessary. Because of the far advanced process in the mastoid and middle ear, few modified radical mastoidectomies were performed. Early surgical intervention would have prevented most of the 41 complications which occurred in 27 cases, or 31 per cent of the series. Cholesteatoma was present in 65 per cent of the cases. The etiology of this tumor is discussed.

Nine of the 13 cases described were cases of far advanced cholesteatoma which illustrate the futility of delaying mastoid operation when it is indicated. One was a case of secretory otitis media and mastoiditis in which there was response only to surgical treatment of the mastoid. The other three were cases of acute suppurative mastoiditis which developed despite the antibiotics, in one of which facial paralysis was a complication.

It is concluded that complications of middle ear and mastoid disease continue despite the antibiotics and that cholesteatoma, a potentially fatal disease in every case, should be treated surgically when diagnosed. Dependence upon the antibiotics has given rise to a false sense of security which has developed complacency on the part of both physician and patient in the treatment of middle ear and mastoid disease. It is stressed that the physician must differentiate between the ears that are likely to respond to medical management and those requiring surgical therapy. Failure to do so and continued conservative care of a cholesteatomatous or other dangerous disease of the ear will lead to progressive disease, loss of function and ultimately loss of life.

Aortic Stenosis of No Physiologic Significance. By Ernest W. Hancock, M.D., William M. Madison, Jr., M.D., Munro H. Proctor, M.D., Walter H. Abelmann, M.D., and George W. B. Starkey, M.D. New England J. Med. 258:305-312 (Feb. 13) 1958.

In seven cases encountered within a period of one year there was sufficient clinical evidence of aortic stenosis to warrant serious consideration of aortic valve surgery. By catheterization of the left side of the heart in five cases and postmortem examination in two cases, significant narrowing of the aortic valve was ruled out. Although several of the features characteristic of aortic stenosis were present in each case, the clinical picture was nevertheless atypical in some respect. The correct diagnosis in five cases was coronary artery disease with myocardial infarction and in two cases mitral valve disease not clearly apparent from clinical findings.

Aortic stenosis and chronic coronary artery disease may cause similar clinical syndromes of cardiac disease. Functionally insignificant pathologic changes in the aortic valve may produce clinical signs indistinguishable from those produced by severe aortic stenosis. Thus, patients with signs and symptoms suggestive of severe aortic stenosis may in fact be suffering predominantly from coronary artery disease. The presence or absence of significant aortic stenosis is objectively established by the findings of catheterization of the left side of the heart. This procedure is indicated whenever surgery of aortic stenosis is under consideration and there is uncertainty about the degree of aortic stenosis present.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

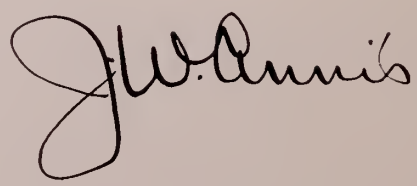
PRESIDENT'S PAGE

Confessional

Until all too recently, I had felt securely smug in the narrow aristocratic confines of our professional enclosure—felt confident that years ago, with my degree Medicinae Doctoris, somehow, Mirabile Dictu, the revered mantle of Medicine with all the dignity, tolerance, humanity and brotherly love that it enfolds, had concomitantly fallen gracefully over my narrow shoulders. I meandered about in this very comfortable fool's paradise until one morning—quite by accident—I caught a revealing and unguarded glimpse of my unadorned and naked soul in the mirror. Here, astonishingly to me, was conceit without performance—was arrogance without nobility—was, indeed, no part of the reflection of Eryximachus, the cultivated, charming, scholarly physician depicted in Plato's Dialogues—a distinguished example of the respect which Medicine achieved in that most brilliant and intellectual age. Instead, I faced one whose interests were sharply limited; whose activities and visions were closely confined by petty and selfish restrictions. I saw Chauvinism and bigotry—intolerance and provincialism to a degree entirely incompatible with figures like Sir Thomas Brown, Sir William Osler, and the other great and wise physicians of the past. I saw a lack of flexibility—a fear of change and innovation, as well as a difficulty of adjustment and of acceptance of new and disturbing thoughts or facts. I saw a tendency toward dogma and dictum; toward rigidity and lack of imagination that impede our progress. And I sought in vain for the eager, all-consuming desire for truth and for a burning interest in and concern for humanity.

I realized, at long last, that what I had received in my graduation years ago was the gift, not of accomplishment, but of opportunity—opportunity to develop and mould myself after the fashion and in the image of the great physicians of the past; and if I would accomplish any part of this, I must forthwith accept my own responsibility in the study of the problems of society at large, and of humanity as a whole—the problems of the total life of man, as well as those pertaining to the narrower field of the science of Medicine. I realized, belatedly, my broader obligations as a physician. It was a disturbing—but I hope a profitable—revelation.

Don't look now—but how well do *you* know that fellow on the other side of the glass?



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Stress and Diabetes In Forensic Medicine

The fascinating implications of Hans Selye's theory of the General Adaptation Syndrome, with his interpretation of the neuroendocrine mechanisms evolved in the animal system by nonspecific "stressor agents," have had some interesting nonclinical results. The "stress theory" has been called upon in recent years to play a rather impressive role in certain legal proceedings involving claims for compensation. The stress mechanisms described in the "alarm reaction" and subsequent phases of Selye's theory have been presented in court as the presumptive causal factors for alleged sequelae of traumatic injury, thus confronting doctors called in as expert witnesses with serious responsibilities.

While Selye's work remains a subject for considerable debate in scientific circles and much of his theory still awaits either confirmatory proof or definite refutation in the experimental laboratory, the extensive publicity provided by lay magazines has undoubtedly made such an impression on many a layman that he has been led into taking Selye's personal opinions and beliefs as articles of faith. It is difficult if not impossible for the average layman to differentiate between what is only the "educated guesswork" of a theory and what is accepted scientific truth. The prestige of a highly publicized name behind a quotation picked out of a book can weigh heavily on a juror's mind at the time of rendering a verdict. This effect has not escaped the attention of certain compensation attorneys who frequently use Selye's book "Stress"[1] as a standard reference manual in the preparation of briefs and have it introduced in court in support of claims for injuries.

Among these claims there have been lately some which refer to diabetes mellitus becoming manifest in a person sometime after accidental injury. In the days before Selye the name used was "neurogenic diabetes." It was claimed that emotional suffering accompanying some severe traumatic injuries would so affect the brain as to disrupt sugar metabolism and result in diabetes. Since Selye's new terminology has become popular, the term used is "stress diabetes." This is of course an attempt to imply synonymity with

"steroid diabetes" and to assume identity with the clinical entity diabetes mellitus in man. Both attempts are based on false premises. Physicians called as expert witnesses should be prepared to assist the court in the proper evaluation of what is theory and what is fact so that a just verdict may be reached and justice and truth be served.

A phrase frequently used by some attorneys in support of their claims for so-called "stress diabetes" is found on page 264, line 22, of Selye's first (1950) edition of "Stress:"[1] "Typical systemic stressors such as psychic or physical trauma may elicit diabetes mellitus in man. Such instances of traumatic diabetes have been interpreted as diseases of adaptation due to derailment of the General Adaptation Syndrome. . . ." It is important to remember that in 1950 probably few had yet realized that there is any difference between "diabetes mellitus in man" and "experimental steroid diabetes." Much new understanding of the mysteries of diabetes has been obtained in the last six or eight years. In Selye's "1955-56 Fifth Annual Report on Stress"[2] one finds on page 166, line 16: "Steroid diabetes is caused by an excess of 11-oxygenated steroids, but we have been unable to exacerbate experimental diabetes by exposing the animals to non-specific stress. Most stressors cause some decrease in the severity of experimental diabetes in the rat. . . ." These words are by one of the book's contributors, Dwight I. Ingle, Ph.D., Professor of Physiology at the University of Chicago and one of the eminent physiologists who have spent years in the study of Selye's theory.

Joslin,[3] quoting Von Noorden, said that "neurogenic diabetes" had been buried by World War I. That observation has been confirmed by other twentieth century wars in which the incidence of diabetes among soldiers, including battle casualties, was found to be even lower than in the general population[4] where both the severity and the incidence of diabetes drop considerably during the stress of war and rebound with the return of peace and prosperity. This war decrease in diabetes has until recently[5] been attributed to the decreased caloric intake accompanying war privations. It is, however, rather striking that soldiers, usually better fed than civilians (and this was particularly so in the German army in both World Wars), would show an even lower incidence. The fact that soldiers are younger has also been adduced, perhaps by those not remembering that diabetes is usually more severe in the young. There was a very wide age range in the German army during the last two years of World War II and it did not seem to make much difference.

Paraphrasing Joslin, it may be said that Ingle has buried "stress diabetes" by proving that stressors do not aggravate and rather seem to improve experimental diabetes in the rat. He further observed:[2] "When the diabetic adrenalectomized rat treated with maintenance doses of cortical extract is exposed to severe stress the glycosuria decreases as though the animal has now become adrenally insufficient. . . ." This observation seems to fit like a glove to the observation that the more severe the stress of war with all its ramifications of prolonged mental and physical torture, the less likely is diabetes to appear and the milder it becomes when already established. Prolonged and severe stress in war must naturally result in a great incidence of adrenal exhaustion with consequent hypoglycemia. It seems reasonable to expect that when adequate studies of adrenal function in large masses of population during the stress of war are made, the general levels of circulating eosinophil counts will be high and those of urinary corticosteroid output will be low.

There are important etiologic differences between the old clinical entity diabetes mellitus in man (similar but not exactly identical with experimental diabetes of pancreatectomized or alloxanized animals) on the one hand, and on the other the separate syndromes of steroid, pituitary and thyroid diabetic states. In the first group the etiology is frankly located in the beta cell system resulting in hypoinsulinism. In the second group the interference with sugar utilization is due to the presence of "insulin antagonists" in excessive amounts.

In clinical diabetes one is dealing with a hereditary or genetic "anlage" with damage to the beta cell system. In the experimental diabetes of pancreatectomy and in that of alloxanized animals one deals with actual suppression of or damage to the beta cells experimentally induced. In both cases the end result is a deficiency in the production of insulin. This group is characterized by the permanency of the hypoinsulinism.

Equivalent to experimental pancreatectomy or alloxanization, an injury to the pancreas would be the only way trauma might cause permanent human diabetes. An injury sufficient to produce that effect, however, would be so destructive that

it is almost inconceivable that it could be compatible with life.[4]

In so-called experimental steroid diabetes, the resulting high blood sugar and glycosuria are not due to lack of insulin but to an excessive gluconeogenesis — at the expense of body proteins — induced by the presence of excessive glycogenic corticoids. The same mechanism governs the diabetic state of Cushing's syndrome. Once the excessive corticoids are removed, blood sugar returns to normal, or to the previous status quo if this situation happens to become superimposed upon a previous state of clinical diabetes mellitus. In the so-called diabetic state accompanying acromegaly and in that accompanying toxic goiter the organism is confronted with the "anti-insulin" or "insulin-blocking" effect of growth and thyroid hormone respectively. These are a normal part of the homeostatic balance which maintains a normal carbohydrate metabolism, but when these insulin antagonists are pathologically overproduced, the normal homeostasis will be broken and high blood sugar with glycosuria will result. Once the acromegaly or the toxic goiter is corrected and the excesses of growth or thyroid hormones are removed, the mechanisms of carbohydrate metabolism will return to the previous status quo.

What most characterizes the clinical entity diabetes mellitus is its being hereditary and permanent while all other disturbances of carbohydrate metabolism are invariably transient and reversible.

The short term results of the so-called "alarm reaction" produced in the clinical diabetic by episodes of mental irritation or anger, or those following the intervention of trauma, infection and other "stressor agents" temporarily affect the course of diabetes mellitus with increases in blood sugar and glycosuria. These effects result from the superimposition upon the clinical diabetic state of a transient increased secretion of glycogenic corticosteroids. That is what produces the temporary imbalances in the control of diabetics when confronted with troublesome problems or when in the presence of trauma and/or infection. Being inherently transient, these, the only possible effects of stress upon diabetes mellitus, usually disappear quickly and leave no sequelae. They certainly cannot be blamed for the production of clinical diabetes mellitus and not even for any permanent aggravation or earlier manifestation.

Clinical diabetes mellitus is a hereditary disease. The genetic predisposition follows Mendelian laws and is as much a part of the individual's hereditary pattern as are the color of the hair and eyes, the shape and arrangement of facial features and body configuration. The tiny genes in the germinal nucleus, like the electronic brain machines, store the physical characteristics along with the "anlage" of beta cell inadequacy within the structure of the chromosomes, probably within the spiral arrangement of molecules of nucleic acid. Many of these hereditary factors and genetic stigmas are present in various degrees of intensity in the billions of spermatozoa of the male progenitor and in the thousands of ova of his female counterpart. Only one of each sex usually combine at the instant of conception. Their individual "genetic load" determines the future newborn's physical structure including whatever pathologic "anlages" happen to be present. No two of these pairs of germinal cells could possibly be identical. Thus, with the exception of identical twins, no two siblings are alike. Brothers and sisters differ in many respects. In the same fashion, diabetics differ as to the time of onset and as to the intensity of their metabolic disorder. The more intense the genetic stigma of diabetes, the earlier the onset and the more severe the pattern of manifestations of the disease. The lighter the "anlage" or pathogenic mark upon the respective gene, the later will the disease become

February Cover



Primitive Medicine Old as Mankind

American Indians made much of primitive medicine, and ancient sandpainting ceremonials of the Navahos are among the more colorful. These ceremonies embody all elements of primitive medicine—religion, magic, chants, physiotherapeutic and psychotherapeutic measures, as well as drug lore. The medicine man chants, sings, prays, and uses magico-religious artifacts and sacred powders in the ritual. (Courtesy of Parke, Davis & Company)

manifest in the individual and the milder will its manifestations be. The superimposition of stress with its inherent mechanisms producing glycosuria and higher blood sugar is always so temporary that Joslin does not consider it possible that a latent diabetic will become a permanent diabetic because of trauma, because diabetes would always revert to its former latency.[3]

The authoritative observations based on the great experience of men like Von Noorden, Joslin, Reed and many others all add up to the recent simple summary by Reed[6] after an exhaustive review of the subject: ". . . neither trauma nor emotional disturbances are etiological factors in producing permanent diabetes mellitus."

1. Selye, Hans: The Physiology and Pathology of Exposure to Stress: A Treatise Based on the Concepts of the General-Adaptation-Syndrome and the Diseases of Adaptation, Montreal, Acta, Inc., 1950.
2. Selye, Hans, and Heuser, Gunnar, editors: Fifth Annual Report on Stress, 1955-56, New York, MD Publications Inc., 1956.
3. Joslin, E. P.: Concerning Trauma and Diabetes, correspondence, Diabetes 6:372-373 (July-Aug.) 1957.
4. Joslin, Elliott P.; Root, Howard F.; White, Priscilla, and Marble, Alexander: The Treatment of Diabetes Mellitus, Philadelphia, Lea & Febiger, 1952, pp. 79 and 84.
5. Goto, Y.; Nakayama, Y., and Yagi, T.: Influence of World War II Food Sbortage on the Incidence of Diabetes Mellitus in Japan, Diabetes 7:133-135 (March-April) 1958.
6. Reed, J. A.: Diabetes and Head Injury: Case in Court, Diabetes 4:377-380 (Sept.-Oct.) 1955.

CARLOS P. LAMAR, M.D.

1959 Annual Meeting. Miami Beach. May 2-6

The Eighty-Fifth Annual Meeting of the Florida Medical Association will be held on May 2-6 at the Americana Hotel, Bal Harbour, Miami Beach. The program has been arranged in accordance with the program for the meeting last year. The organizational work of the Association has been separated from the scientific sessions in order to avoid conflict in interests. Tuesday, May 5, will be devoted completely to the scientific program in order to permit the members who find it impossible to attend the entire session to come for one full day of scientific discussions. Work sessions of the House of Delegates have been divided so that adequate time is available Sunday afternoon as well as Wednesday morning for accomplishing the necessary work.

A change has been made in the time allotted for specialty group meetings. Due to the discontinuance of the Association's banquet, it is possible for specialty meetings to be scheduled on Tuesday evening as well as on Saturday and on Sunday morning. Tuesday evening seems an appropriate time, particularly if any of the specialty groups would like to have a banquet to accompany their session.

The General Session on Monday morning will be unusually interesting with addresses by a representative of the American Medical Association and by the President's guest speaker. Furthermore, at this session prominent out-of-state speakers are scheduled to review the progress of research in the field of cardiovascular diseases and also in relationship to broad meanings behind the physiologic processes which have been elucidated by the newer discoveries made since the development of the corticoids.

It has been impossible to schedule for the Association program all the outstanding speakers who have been invited by the specialty societies. In fact, never before has there been so much talent to select from as this year.

Panels and symposiums will be utilized again. A panel on cardiovascular diseases has been planned for Tuesday morning and a symposium on the third greatest cause of death in the afternoon. The importance of psychosomatic diseases and their recognition makes a paper on a neuropsychiatric subject timely, especially in view of the increasing number of elderly persons in the population of Florida. Other scientific papers will cover the medical and surgical aspects of diseases of the chest and metabolic diseases, and will also give consideration to Florida's contribution to the problem of one of these diseases. The second session of the House of Delegates on Wednesday concludes the meeting.

The Scientific Exhibit will be located near the meeting room. The Hotel Americana exhibit hall has a triangular arrangement and the meeting room has been constructed at the apex of this triangle. Consequently, the Scientific Exhibit will be adjacent to the rear of the meeting room, and the technical exhibits will be around the scientific exhibits. This arrangement will allow all members of the Association ready access to all of the interesting exhibits as well as quick access to hear particular papers. Motion pictures, except as a

part of the Scientific Exhibit, have not been made a part of the program this year.

Members are urgently requested to note that there is still at this printing some space available for scientific exhibits. If they will request space immediately, it can be allocated for their use.

The program as a whole allows adequate opportunity for a balanced scientific program of postgraduate education and much needed rest and relaxation. Many members may wish to attend the convention and remain a day or two afterward or come a day or two early, merely for pleasure or to attend specialty group meetings. The excellent program, coupled with the attractions of the hotel and the Miami area, should draw an unusually large attendance.

Lawrence E. Geeslin, M.D., *Chairman*
Committee on Scientific Work

First Conference of County Medical Society Presidents and Secretaries Held

The First Annual Conference of County Medical Society Presidents and Secretaries, sponsored by the Florida Medical Association, was held at Sellers Auditorium, the home of the Duval County Medical Society, in Jacksonville on Dec. 14, 1958. It proved to be a most auspicious occasion which augured well for such a meeting as an annual feature of the Association's program.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, presided at the morning session. In his welcoming remarks he declared that the purpose of the Board of Governors in arranging the meeting was to improve communications and strengthen professional relations between the offices of the Association and its component societies. He stated that the Board hopes, in gathering together the newly elected county society officers each year, to make their task easier by explaining in some detail the method of operation of the Association office, the plans for the ensuing year, the currently active projects, and the past policies and precedents, and by giving them much of the material that they will need to pass on to their constituent members. The meeting likewise affords the Board of Governors and the Association's staff the opportunity to



Interest in the program of the First Annual Conference of County Medical Society Presidents and Secretaries is evident in this view of the audience.



Dr. Howard

learn from the chosen leaders of the various component societies the feelings, the wishes and the reactions of their members.

"Our Positive Public Relations Program" was the subject presented by Dr. Edward Jelks of Jacksonville, Public Relations Liaison, Board of Governors. He also reviewed the plan of organization of the Association's Executive Office and spoke briefly about the Florida Medical Foundation, of which he is the president.

Dr. William C. Roberts of Panama City, Immediate Past President of the Association, discussed "The Responsibilities of the County Medical Society President," and Dr. Samuel M. Day of Jacksonville, the Association's Secretary-Treasurer, spoke on "Duties of the County Medical Society Secretary." Dr. Roberts emphasized the prestige as well as the demands of the presidential office and urged familiarity with the problems and programs on the county, state and national levels and wise planning to assure advancement of the county society. The key role of the society secretary was stressed by Dr. Day, who made helpful suggestions to expedite the secretary's meticulous task.

Dr. Ernest B. Howard of Chicago, Assistant Executive Vice President of the American Medical Association, discussed "Current Problems and Programs of the AMA." He gave a kaleidoscopic review of the sweeping changes made in recent months in reorganizing, streamlining and strengthening the administrative structure of the 111 year old national organization and discussed some of the problems currently confronting organized medicine at the national level. In a masterful presentation he pictured the parent organization forging ahead under the direction of the seven newly created divisions of the headquarters staff, namely, Business, Law, Communications, Field, Scientific Publications, Socioeconomic Activities and Scientific Activities.

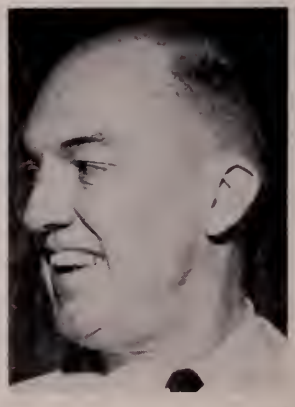
The broad subject of "Legislation—Past and Future (State and National)" was presented by Dr. H. Phillip Hampton of Tampa, Chairman of the Association's Committee on Legislation and Public Policy. He gave a comprehensive summary of pressing legislative problems. Dr. Burns A. Dobbins Jr. of Fort Lauderdale, Chairman of the Medicare Mediation Committee, then reviewed Medicare legislation and explained the recent changes in the Medicare program.



Dr. Annis



Dr. Jack



Dr. Day

Mrs. Lee Rogers Jr. of Rockledge, President of the Woman's Auxiliary to the Florida Medical Association, in an excellent presentation graphically portrayed the Auxiliary's many and varied activities. She cited such important projects as assistance relating to socioeconomic conditions, cooperation in the new programs to improve the health of the aged, promotion of the circulation of Today's Health, liberal contributions to the American Medical Education Foundation and an active program for the recruitment of students for paramedical careers as part of the Auxiliary's work supplementing the program of the national, state and county medical societies.

Dr. Day presided at the afternoon session. Featured on the program at this session was a Panel on Medical Economics and Insurance, in which Dr. S. Carnes Harvard of Brooksville, First Vice President of the Association and Chairman of the Committee on Medical Economics, and Dr. Robert E. Zellner of Orlando, former Committee chairman, participated. Dr. Edward R. Annis of Miami, Chairman, made a progress report on the Governor's Citizens Medical Committee on Health, and Dr. Russell B. Carson, President of Blue Shield, spoke on "Our Blue Shield."

Concluding the program, Dr. Annis chose for his subject "Things to Watch For." Declaring the meeting highly successful, the Association's President reviewed the highlights of the program and summarized the many constructive suggestions the presidents and secretaries were urged to utilize in the year ahead to promote cooperation and progress in their respective societies.

An interesting closing feature of both the morning and afternoon sessions, "I've Got a Question," was conducted by Dr. Ralph W. Jack of Miami, President-Elect of the Association. The range of questions from the floor bespoke wide interest. The comments of the presidents and secretaries in attendance were most gratifying, and their suggestions as to how the Association might serve them best were particularly helpful to the Association's officers and staff. Since the meeting, many letters have been received expressing appreciation, favoring the Conference as an annual event and offering comments and suggestions that will guide future plans.

At the noon hour a complimentary luncheon was served at the nearby Florida Medical Association Building, and a tour of the Association's headquarters was conducted.

Twenty-One County Societies Represented at Conference For Presidents and Secretaries

Twenty-one of the 37 constituent medical societies of the Florida Medical Association were represented by a total of 34 physicians at the First Annual Conference of County Medical Society Presidents and Secretaries held Dec. 14, 1958, at Sellers Auditorium in Jacksonville.

Ten county societies were represented by both the president and the secretary. These included: Bay: Drs. James D. Nixon and Robert L. Overman, Panama City. Dade: Drs. Robert P. Keiser, Coral Gables, and DeWitt C. Daughtry, Miami. Duval: Drs. Samuel M. Day and Ray O. Edwards Jr., Jacksonville. Lee-Charlotte-Henrdy: Drs. Wilson A. Rumberger and James C. Carver, Fort Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson: Drs. Hilliard R. Reddick, Quincy, and Nelson H. Kraeft, Tallahassee. Marion: Drs. Earl E. Yantis and Wallace E. Winter, Ocala. Pasco-Hernando-Citrus: Drs. Alfred G. Brown Jr., Inverness, and W. Wardlaw Jones, Dade City. St. Johns: Drs. William J. Gibson and Joseph A. Shelley, St. Augustine. St. Lucie-Okeechobee-Martin: Drs. Robert F. Meeko and Maltby F. Watkins, Ft. Pierce. Volusia: Drs. Alphonsus M. McCarthy and John J. Cheleden, Daytona Beach.

Nine county societies were represented by the president. These included: Alachua: Dr. George H. Putnam, Gainesville. Broward: Dr. Miles J. Bielek, Fort Lauderdale. DeSoto-Hardee-Highlands-Glades: Dr. James G. Smith, Wauchula. Orange: Dr. Robert L. Tolle, Orlando. Polk: Dr. Newell J. Griffith, Winter Haven. Putnam: Dr. Charles E. Barrineau, Palatka. Sarasota: Dr. Andrew J. Jesacher, Sarasota. Seminole: Dr. Vann Parker, Sanford. Suwannee-Hamilton-Lafayette: Dr. James F. Dietrich, Live Oak.

Two county societies were represented by the secretary. These were: Brevard: Dr. Louis C. Jensen Jr., Cocoa. Pinellas: Dr. Whitman C. McConnell, St. Petersburg.

The Dade County Medical Association was also represented by Dr. Hunter B. Rogers and Dr. John D. Milton, both of Miami, and the Duval County Medical Society by Dr. Leo M. Wachtel, of Jacksonville.

Three county medical societies sent their executive secretaries: Mr. M. John Hanni Jr., Dade; Mr. Marshall Brainard, Duval, and Mrs. Amelia Hapke, Hillsborough.

Physicians serving on the program representing not only their county medical society but also the Florida Medical Association included Drs. Jere W. Annis, Lakeland; Ralph W. Jack, Miami; William C. Roberts, Panama City; Samuel M. Day, Jacksonville; H. Phillip Hampton, Tampa; Burns A. Dobbins Jr., Fort Lauderdale; Edward Jelks, Jacksonville; S. Carnes Harvard, Brooksville; Robert E. Zellner, Orlando; Edward R. Annis, Miami, and Russell B. Carson, Fort Lauderdale.

Representatives from the American Medical Association included Dr. Ernest B. Howard, Mr. Charles Johnson, and Miss Jean Pascoe, all from Chicago.

Mrs. Lee Rogers Jr., of Rockledge, officially represented the Woman's Auxiliary to the Florida Medical Association.

Mr. H. A. Schroder, of Jacksonville, represented Blue Cross-Blue Shield, and Mr. Harry T. Gray, also of Jacksonville, appeared as attorney for the Florida Medical Association.

Association Issues New Handbook To Component Medical Societies

The Handbook for County Medical Societies, a new publication prepared by the Florida Medical Association, was released during the Conference of County Medical Society Presidents and Secretaries held in Jacksonville on Dec. 14, 1958.

Prepared to assist component society officers and committee chairmen in establishing and maintaining active programs, the Handbook provides concise descriptions of many of the Association's programs of which the local societies are an integral part. In presenting the Handbook to physicians attending the conference, President Jere W. Annis stated, "As a lasting result, it is hoped that the Handbook will help achieve better understanding of state programs and policies and their relationship to the county society, improved orientation of new society officers and committee chairmen, and increased continuity and coordination of society programs."

A foreword to the society president opens the Handbook. Following a section devoted to the society secretary are sections concerning various committees. These sections are titled by general subject only, since committee names and assignments differ somewhat among societies. Because programs are subject to revision as needs and conditions change, the Handbook is assembled in an attractive loose-leaf binder to permit easy addition of new or revised sections. Included in the initial edition are sections on public relations, medical economics, legislation and grievance. It is anticipated that new sections will be added from time to time. Concluding the Handbook is an appendix which consists of a brief description of the Florida Medical Foundation and of a model county medical society constitution and by-laws that will be added at a later date.

The Handbook, which will be furnished to all county medical society presidents and secretaries, is intended to be passed on to succeeding society officers each year. In the final sentence of the foreword to the society president, the Association's Board of Governors expressed the ". . . sincere hope that this Handbook for County Medical Societies will remain an integral and well used part of every society's library."

Investors League Hears Dr. Annis

Addressing the Florida Division of the Investors League at its meeting in Winter Haven on January 19, Dr. Jere W. Annis, President of the Florida Medical Association, clarified at the outset the attitude of the medical profession on the basic human right of freedom of enterprise. "Certainly this profession of ours, which is the oldest of all professions, has ever been one which has advocated and carried out a system of free enterprise—a system advocating a completely free and unrestrained search for truth—a system of freedom of action, thought, belief and enterprise, where the importance of opportunity and accomplishment replaces that of security. Physicians, like priests, have died for their beliefs and for the refusal to give even lip-service to a lie or a liar—or a dictator. And physicians today resent and oppose regimentation in any form which will hamper their freedom of action—their freedom to practice their art. . . . We believe that competitive and unrestrained enterprise is essential for that sense of achievement—that sense of accomplishment—which is so necessary for our physical, mental and moral growth. This is the reason that we feel so strongly that freedom of choice of a physician—and a physician of his patients—is so necessary to our way of life."

Dr. Annis then discussed indigent medical care within the state and medical care of the

state's aging population, two problems in which the Florida Medical Association has taken keen interest and decisive action. He expressed the profession's conviction that the care of the indigent is the obligation of the neighborhood, the community, the county and, lastly, the state and that the federal government should not be called upon for financial aid nor should it insert itself into financing of this care. He cited the recommendation of the committee, appointed by Governor Collins at the suggestion of the Florida Medical Association to study the problem of indigent medical care, which resulted in the state legislature appropriating $4 million for the last biennium to defray hospital expenses for medically indigent persons. After explaining the procedural technicalities involved in this program participated in by practically all of the counties in the state, he commented that the program has worked well and has just about used up the funds at the scheduled rate. In other words, about half a million dollars is being spent quarterly for this program.

With regard to the medical care of the state's aging population, Dr. Annis pointed out the unsoundness of the Forand Bill. "We of the Medical Association are well aware that there is no logical or scientific basis for the enactment of this type of legislation. The idea of adding the medical, surgical and hospital care of some 13 million Americans to a program which is already basically unsound and insolvent, as is the Social Security program, is so ridiculous as to be laughable, if the seriousness of the situation were not so apparent. Indeed, the only thing which outstrips the unsoundness and ridiculousness of this type of legislation is its vote-getting ability."

The medical profession of Florida is now cooperating with certain other agencies on a statewide basis in conducting a thorough and complete investigation with a view to outlining definitely and scientifically the problem of supplying adequate medical care to the aging population and then propounding a reasonable solution. "Here again," Dr. Annis continued, "we become involved as to whether the responsibility of this aging population is a federal or a local and state obligation—whether we are duty- and honor-bound to take care of our own in sickness and in health, or whether we should pass on the responsibility of their care to an omnipotent and somewhat callous federal government.

"These principles can never be reconciled. We must accept the obligations implied in a government based on the principle of states' and individual rights, if we are to reap its rewards. We must believe either in the competitive free enterprise system of our forefathers which has made America a great country—or we must believe in the strong, centralized anarchistic or fascist governments of Europe. We must make up our minds whether we wish to rear our families in a democracy or in a socialistic state. And, having made up our minds, we must act accordingly to see that the proper legislation is enacted in Washington which will support our views."

Dr. Annis concluded with a plea that groups such as the Investors League throughout the country make their voices heard and their will known—now in the face of an approaching election year—lest the country be inundated by the threatening and all-engulfing wave of Socialism.

Veteran Editor Resigns

The announcement of the resignation of Dr. Austin Smith as editor of The Journal of the American Medical Association was received in the world of medical journalism with genuine regret. Dr. Smith gave up his editorial responsibilities on Dec. 15, 1958, after a decade of service in this top editorial post and 18 years of service with the American Medical Association. He succeeded Dr. Morris Fishbein, and in addition to being editor of the The Journal of the American Medical Association, he directed the editorial policies of that association's nine monthly specialty journals.

A native of Canada, Dr. Smith received his medical training there and in New York. He served for two years as a member of the Department of Pharmacology of Queen's University, Kingston, Ontario, his alma mater, and later as a member of the staff of the University of Illinois College of Medicine in Chicago. For many years, he was a professional lecturer at the University of Chicago in the Department of Pharmacology. He served for some years as secretary of what is now known as the Council on Drugs of the American Medical Association, and for a number of years was also director of the Division of Therapy and Research.

Dr. Smith has written scores of articles and books, both popular and scientific. The Journal

of the Florida Medical Association extends to this distinguished editor and author every good wish and wishes him continued success as he elects new fields of endeavor.

1959 Atlanta Graduate Medical Assembly February 16-18, 1959

Plans are complete for the largest and most comprehensive Atlanta Graduate Medical Assembly in the 17 year history of this most popular Dixie medical meeting. The dates are February 16, 17 and 18, and, as usual, the sessions will be held in the Convention Hall of the Atlanta Biltmore Hotel.

The exceptionally well qualified faculty selected this year will offer the widest variety of medical specialty topics ranging from Allergy to Nuclear Medicine. Each speaker is a recognized leader in his field and each has made prominent and recent contributions to the profession for which he has received wide acclaim. The names read like a "Who's Who" in the latest outstanding medical achievement poll.

The fourteen speakers, their specialty fields and home bases are:

Internal Medicine, Dr. Stewart G. Wolfe Jr., University of Oklahoma, Oklahoma City; Allergy, Dr. Ethan Allan Brown, Boston; Endocrinology, Dr. Edward H. Rynearson, Mayo Clinic, Rochester, Minn.; Gastroenterology, Dr. William G. Sauer, Mayo Clinic, Rochester, Minn.; Hematology, Dr. William Dameshek, New England Center Hospital, Boston; Surgery, Dr. B. Marden Black, Mayo Clinic, Rochester, Minn., and Dr. Warren H. Cole, University of Illinois, Chicago; Cardiovascular Surgery, Dr. Denton A. Cooley, Baylor University, Houston; Pathology, Dr. Averill A. Liebow, Yale University, New Haven, Conn.; Radiology, Dr. Charles M. Nice Jr., Tulane University, New Orleans; Anesthesiology, Dr. Vincent J. Collins, New York University, Bellevue Medical Center, New York City; Obstetrics and Gynecology, Dr. Curtis J. Lund, Strong Memorial Hospital, University of Rochester, Rochester, N. Y.; Pediatrics, Dr. A. Ashley Weech, University of Cincinnati, Cincinnati; and Nuclear Medicine, Dr. Lee E. Farr, Brookhaven National Laboratory, Upton, Long Island, N. Y.

A most popular feature of the Assembly has been the scheduling of "Luncheon Conferences" and small afternoon "Roundtables" where attending doctors can get together informally in small groups with one or two of the visiting speakers and exchange questions and answers in an easy, relaxed "no holds barred" fashion. More of these popular luncheon conferences and roundtables have been added to this year's schedule in response to increased demand.

Not all topics discussed are strictly medical. For example, Dr. Charles M. Nice Jr., who comes from Tulane University School of Medicine to address the Assembly in regular session on his specialty, Radiology, is also one of the nation's recognized top authorities on "Dixieland Jazz." He will lecture on this "topic" at a special expanded luncheon conference on Tuesday, February 17, to which the attending doctors' wives are invited with their husbands—a rare and appreciated privilege.

Last year, over 1,600 medical people attended the Assembly. This year an even larger record crowd is expected. The course offered is approved by the American Academy of General Practice for 15 hours' credit in Category I.

Advance registration saves time and confusion. The fee is $15. Checks should be sent to the Atlanta Graduate Medical Assembly, 875 West Peachtree St., N. E., Atlanta 9, Ga.

The New Orleans Graduate Medical Assembly

The Twenty-Second Annual Meeting of The New Orleans Graduate Medical Assembly will be held March 2-5, 1959, in New Orleans with headquarters at the Roosevelt Hotel.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposiums, medical motion pictures, round table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Mexico City, Cuernavaca, Taxco, Acapulco and San Jose Purua. The party will leave New Orleans on Friday, March 6, and return on Saturday, March 21.

Details of the New Orleans meeting and the clinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Sixth Annual Cardiovascular Seminar
Jacksonville, Feb. 19-21, 1959

The Northeast Florida Heart Association will present the annual Seminar on Cardiovascular Diseases at the Prudential Auditorium in the Prudential Building in Jacksonville on February 19-21. The course is accepted by the American Academy of General Practice for 15 hours' credit in Category I. Registration will begin at 8:30 a.m. on February 19 at the Auditorium. The registration fee is $10, and no charge is made for residents, interns and physicians in the armed services. The Hotel Roosevelt is the downtown headquarters, and reservations may be obtained by contacting the hotel or the Northeast Florida Heart Association, 1628 San Marco Boulevard, Jacksonville.

The distinguished faculty, announced in the January issue of The Journal, consists of Dr. Samuel A. Levine of Boston, Dr. Victor A. McKusick of Baltimore, Dr. Max Michael Jr. of Gainesville and Jacksonville, Dr. A. G. Morrow of Bethesda, Md., Dr. William J. Taylor of Gainesville, Dr. Myron W. Wheat Jr. of Gainesville, and Dr. Irving S. Wright of New York.

Group luncheons are planned in the St. Johns Room on Thursday and Friday, and the annual banquet will be held at the Timuquana Country Club on Friday night, February 18.

The Seminar has the endorsement of the Florida Heart Association, and co-sponsors are the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida Medical Association and the Florida State Board of Health.

The program follows:

SIXTH ANNUAL CARDIOVASCULAR SEMINAR
PRUDENTIAL BUILDING, JACKSONVILLE, FEBRUARY 19-21, 1959

THURSDAY, FEBRUARY 19		Presiding: Dr. Daniel R. Usdin
8:30	Registration	
9:30	"Clinical Axioms Concerning Heart Sounds"	Dr. McKusick
10:05	"Overlooked Clinical Manifestations of Impaired Cardiac Function"	Dr. Taylor
10:40	Recess	
11:00	"Subacute Bacterial Endocarditis"	Dr. Michael
11:35	"Clinical Interpretations of Cardiac Murmurs"	Dr. McKusick
12:15	Lunch	
		Presiding: Dr. Hugh A. Carithers
2:00	"Selective Angiocardiography and Aortography in the Assessment of Congenital and Acquired Heart Disease"	Dr. Morrow
2:30	"Adjunctive Measures of Value During Cardiac Surgery"	Dr. Wheat
3:00	Recess	
3:15	"Diagnostic Studies in the Characterization of Circulatory Shunts"	Dr. Morrow
4:00	Panel Discussion: "Cardiovascular Surgery" Moderator: Dr. Arthur Nelson	Drs. McKusick, Morrow, Taylor, Wheat and Roy Baker
FRIDAY, FEBRUARY 20		Presiding: Dr. W. Hugh Mathews
9:00	"Errors in Care of Cardiac Patients"	Dr. Levine
9:35	"Recent Advances in the Use of Anticoagulants"	Dr. Wright
10:10	Recess	
10:30	"Cardiovascular Aspects of Heritable Disorders of Connective Tissue"	Dr. McKusick
11:05	Panel Discussion: "Cor Pulmonale" Moderator: Dr. Max Michael	Drs. Levine, McKusick, Morrow and A. E. Anderson
12:00	Luncheon—St. Johns Room Speaker: "Medicine in Europe"	Dr. Irving S. Wright

Presiding: Dr. George Anderson

1:30	"The Present Status of Extracorporeal Circulation in the Surgical Treatment of Congenital and Acquired Cardiac Lesions"	Dr. Morrow
2:10	"Strokes. Diagnosis and Treatment"	Dr. Wright
2:50	Recess	
3:00	Panel Discussion: "Atherosclerosis" Moderator: Dr. Mason Romaine	Drs. Levine, McKusick, Morrow and Wright
4:00	Recess	
4:15	"Types of Medical Thinking"	Dr. Levine
7:00	Banquet—Timuquana Country Club	

SATURDAY, FEBRUARY 21 Presiding: Dr. William E. Faris

9:00	"Some Puzzling Points About Coronary Artery Disease"	Dr. Levine
9:40	"Observations on the Cardiovascular System in Patients with Collagen Diseases"	Dr. Taylor
10:15	Recess	
10:35	"Genetic Factors in Cardiovascular Disease"	Dr. McKusick
11:05	Question and Answer Period	

Southeastern Surgical Congress Miami Beach Assembly March 9-12, 1959

An elaborate scientific program will be presented by distinguished guest lecturers and members at the meeting of the Southeastern Surgical Congress in Miami Beach on March 9 to 12. The papers cover a wide range of subjects, and three panel discussions are scheduled. The subjects of these discussions are "Treatment of Advanced Cancer of the Breast," "Management of Gynecologic Problems" and "Trauma." Among the Florida physicians scheduled to present papers are Drs. H. Clinton Davis, John J. Farrell, Richard M. Fleming and James Ferguson of Miami, Arthur R. Nelson and Alan Kline of Jacksonville, and Jesse W. Castleberry of Orlando.

The Deauville Hotel is the headquarters for the meeting. Dr. B. T. Beasley, Secretary-Director General of the Congress, urges that hotel reservations be made early by writing the hotel manager. The tentative program appears elsewhere in this issue of The Journal and the completed program will be ready by February 15. Address Dr. Beasley at 1032 Hurt Building, Atlanta 3, Ga., for further information.

Dr. Lawrence E. Geeslin, Chairman of the Committee on Scientific Work, has announced that the program for the 1959 Annual Meeting of the Association will be published in the April issue of The Journal.

OTHERS ARE SAYING

Horse and Buggy Patient

It is almost impossible to pick up a magazine of national distribution nowadays without finding some reference either direct or implied to the high cost of medical care and decrying the passing of the good old horse and buggy doctor. Rather than allowing ourselves to be put on the defensive it seems to me that we as doctors should take a more positive position on this subject. Recently Dr. Louis Dublin, retired vice-president and former chief statistician of the Metropolitan Life Insurance Company, began a speech before a civic club with this statement: "I am well aware of the advances which have been made in recent years in atomic physics but the greatest achievement in the history of man has been the increase in life expectancy which has occurred since 1900." He went on to say that the life expectancy in 1900 was 49 as opposed to 70 in 1956 and that the 21 year increase is equal to that which has occurred since the dawn of recorded history up to 1900. He also pointed out that in the past 57 years the productive lifetime of this average man has been increased by 19 years. This means fewer widows, fewer orphans, fewer people on the public dole.

These achievements have not been the accomplishment of horse and buggy doctors but of highly trained physicians who are constantly

striving to keep abreast of new developments and new information. The average man is getting the best bargain in medical care that he has ever gotten and at fees which have not changed materially in the past 50 years. No longer is it possible to carry all medical knowledge in a little black bag nor is it possible to operate at the pace of a horsedrawn buggy. And if it were, the public, our patients, would not permit it.

It would be a refreshing experience to meet a good old horse and buggy patient for a change, one who presented himself to his doctor saying, "Doctor, I'm sick. Do what you can to get me well." And then doesn't insist on a detailed explanation of the meaning of each symptom and of why the cause of his trouble isn't something other than what his doctor thinks it is. The horse and buggy patient is as anachronistic as his medical counterpart. The patients we see now are better educated and better informed, and are no longer willing to accept an "act of God" explanation for medical disasters which they feel are explainable.

As we approach the age of definitive medicine when a physician can actually do something for his patient rather than commiserate with him over his misfortune, medical practice has become more and more impersonal. Our horse and buggy predecessor was strictly limited in what he could do for his patient. Calomel and sympathy were the main ingredients of his prescription. While the calomel is rather outmoded, sympathy, or interest in the patient as a person rather than a case, is still a potent factor in the treatment of any patient. What he sometimes misses in us as medical practitioners is not the horse and buggy doctor's limited knowledge of medicine but his great knowledge of human nature and human needs. There is no better combination than modern medical knowledge and modern medical methods and old-fashioned interest in patients as people.

Most people are willing to pay for anything they buy if they are convinced it is worth the price. We have a responsibility to our patients not only to provide the best of care but to let them know what they are paying for and what they are getting. Call it what you like it is still salesmanship and good selling means more satisfied patients, fewer references to the good old days, and less talk about the high cost of medical care. We have a product to sell of which we are justly proud, but what we think of the value of our services is of no real importance unless our patients agree with us. We need offer no apologies for practicing good medicine, even if it appears to be expensive, but we do need to educate our patients about the value of our services.

No one is important unless someone else thinks he is. If the right of free choice of physician is to be preserved, it is up to us to make it important to the patient. When the patient becomes "that nice little Mrs. Jones" instead of "that gall bladder" the physician becomes "my doctor" rather than "a doctor." The preservation of medical practice as we know it depends not on the government but on how well we, the members of the medical profession, are able to instill in our patients' minds the difference between "a doctor" and "my doctor."

Robert E. Zellner, M.D., President
Orange County Medical Society
Quarterly Bulletin
July, August, September, 1958

STATE BOARD OF HEALTH

Crossroads Cancer Seminar
March 10-13, 1959

The Crossroads Cancer Seminar is held every other year in some of the smaller cities of the state in cooperation with the Florida Division of the American Cancer Society, the Florida State Board of Health, and the local county medical societies. This year the speaker will be Dr. John D. Pigott of Memphis, Tenn., who is a graduate of Northwestern University Medical School, a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and a member of many other societies.

Dr. Pigott received part of his training at the Methodist Hospital in Memphis and additional training at the Memorial Center for Cancer and Allied Diseases in New York City. At the present time he is associated with Dr. Ralph R. Braund in the field of surgery and oncology. He will discuss cancer of the rectum and colon.

The Seminar will be held in Pensacola, March 10; Panama City, March 11; Live Oak, March 12 and St. Augustine, March 13. The place of the meeting may be obtained by contacting the local medical society in each of these cities.

BLUE SHIELD

Health Care For Senior Citizens

Is there a problem? Most people agree that there is a problem. In Florida, a great deal of determined effort and time have been put into defining and researching this problem of health care for the aged by a Citizens Committee appointed by the Governor of Florida, working with Florida Medical Association and other interested groups. The Florida Medical Association's Committee on Aging, headed by Dr. Samuel Gertman of Miami, requested and received financial aid from the Blue Shield Board of Directors for a survey to determine the need. Their recommendations for action will be vital and specific. The House of Delegates of the American Medical Association recently recognized the need and recommended that a special low fee schedule and low income prepayment plan be devised for the aged.

Is anything being done now? Prepayment of medical care for the elderly has long been a matter of urgent and continued concern to the medical profession and its Blue Shield Plans. Within the past year, however, this problem has been made something of a political issue through the introduction of such legislation as the Forand Bill, which, if adopted, might radically affect the future of the entire voluntary health care movement in America. At the present time, 18 per cent of the persons covered by Florida's Blue Shield and Blue Cross Plans are over 65 years of age. This means that approximately 100,000 Florida senior citizens now have this coverage. Nationally, Blue Shield has enrolled two and one-half million persons over 65 years of age, who represents about two thirds of the people over 65 who have medical-surgical coverage. It is estimated that about 15 million people in the United States are over 65 years old, and are not cared for by an established institution or agency.

Blue Shield has always sought to service medicine's inescapable responsibility to the whole community. It was until recently almost an exclusively Blue Shield feature that any member on retirement, or on leaving an insured group, could retain his coverage by "conversion" to a "direct-pay" basis.

The Florida Plans impose no age limit on group enrollment and, as of Jan. 1, 1959, impose no age limit on those who apply for nongroup coverage.

What are the prospects for the immediate future? It is apparent that even though organized medicine, through Blue Shield, has continually sought to provide prepayment for this age group, more needs to be done. The Florida Medical Association was quick to recognize this need, and its House of Delegates meeting in May of 1958 recommended to Florida Blue Shield "that a study be made of the possibilities of a special category old age contract with low fee schedule and low service benefits."

Blue Shield is aware of medicine's responsibility to our senior citizens, and is prepared to respond to the guidance and leadership of the profession in helping it meet this challenge.

LETTERS TO THE EDITOR

Dear Dr. Richardson:

With a melancholic satisfaction, I am writing you relative to a statement in the October issue of The Journal. It read, "So far it has not been possible to obtain photographs of all the past presidents." Among the names on the list was that of Dr. John P. Wall of Tampa. Dr. Wall was one of the founders of the Florida Medical Association and the Florida State Board of Health. He was president of the Florida Medical Association in 1884. He dropped dead while delivering his inaugural address in Gainesville.

I am happy to report that I succeeded in finding what is purported to be the only photograph of him in existence. It now occupies the honored niche provided for him in the Association's Executive Office.

I also noticed among those whose photographs were missing the names of several heroes of the great yellow fever epidemic of 1888 that practically involved the entire state. Some were collaborators of that brilliant U. S. Army bacteriologist, Dr. Walter Reed, who had been sent to Florida to investigate the cause and method of transmission of yellow fever.

I am convinced that every photograph of those esteemed old pioneers of the swaddling days of medicine in Florida could be found if someone in their particular districts could be aroused from a standpoint of reverence for those dear old souls who burned their life like a swift devouring candle



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

in their eagerness to help those whose descendants are today enjoying the fruits of their labor.

In this sad neglect on our part, I am reminded of the words of the great poet, Charles Wolf:

Slowly and sadly, we laid him down
From the field of his fame, fresh and gory
We carved not a line and we raised not a stone,
But left him alone with his glory.

I am wholly incapable to do justice to the memory of these pioneers of our profession. While they were denied the modern day equipment to aid them in their diagnosis and treatment, they possessed other gifts and versatilities that made them geniuses. They touched the hearts of the populace with their sweet nature and unblemished characters, and I feel that we should go all out to prove our undying loyality to these old masters of the past. To them, the day's work was never over. It was their love for their fellow man that carried them over the rough roads and through the dark nights with their faithful dobbin, and serenely smiling through the valley of the shadows as the Creator's fingers touched them. Now they sleep as our forgotten heroes.

Sincerely,
W. M. Rowlett, M.D.

Dear Sir:

The Veterans Administration has set up a laboratory in Jacksonville for the study of the epidemiology and etiology of sarcoidosis. It has been shown that the heaviest concentration of patients with this disease is in the southeastern United States. Furthermore, this distribution corresponds closely to that of the pine tree forests. Work in this laboratory has shown the pine pollen to be acid-fast and to contain substances also found in extracts of sarcoid tissue. Further work in this field is in progress.

In order to make our epidemiologic study complete, we would be very much interested in seeing any patient with this disease. We need further information on epidemiology, skin testing, and certain serologic tests on patients in this area. During the next 18 months I will be in various areas of Florida and could look up any patient whose name and address have been given to us. If the patient lives within the Jacksonville area, he could be seen in this office.

Your help in furnishing us the names of any patients with sarcoidosis who would be willing to participate in this study will be greatly appreciated.

C. F. McCuiston, M.D., Director
Special VA Sarcoidosis Research Clinic
Box 4795
Jacksonville 1, Florida

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STATE NEWS ITEMS

Emory University School of Medicine has announced a postgraduate course in "Congenital Heart Disease" for March 27-29 at Grady Memorial Hospital, Atlanta. The faculty consists of Dr. S. Gilbert Blount Jr., Associate Professor of Medicine, University of Colorado, Denver; Dr. Richard G. Lester, Assistant Professor of Radiology, University of Minnesota, Minneapolis; Dr. John W. Kirklin, Assistant Professor of Surgery, University of Minnesota Graduate School, Rochester, and members of the faculty of Emory University School of Medicine. The fee is $50. Information may be obtained by contacting Postgraduate Education, 69 Butler Street, S. E., Atlanta 3, Ga.

Drs. Jack H. Bowen, Joseph A. J. Farrington and Lauren M. Sompayrac, all of Jacksonville, attended the American Academy of Dermatology and Syphilology meeting in Chicago in December.

The Greater Miami Eye, Ear, Nose and Throat Society meets quarterly in March, May, October and December on Thursday evenings at the McAllister Hotel, Miami, and has elected the following officers for 1959: president, Dr. Mariano C. Caballero; vice president, Dr. Joseph Freeman, and secretary-treasurer, Dr. H. Carlton Howard.

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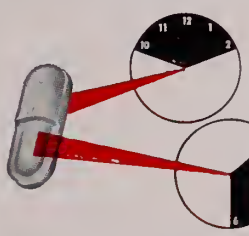
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†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Dr. Albert V. Hardy of Jacksonville, Assistant State Health Officer, was a member of the panel directed to prepare recommendations for the study and control of diarrheal diseases throughout the world which reported during the meeting of the World Health Organization held the latter part of November in Geneva, Switzerland. Other members of the panel were from London, Brazil, Senegal, Yugoslavia and Russia. Dr. Hardy was accompanied on the trip abroad by his wife, Dr. Grace C. Hardy.

Dr. Geoffrey H. Binneveld of Leesburg has been elected vice president of the Lake County Unit of the American Cancer Society.

Dr. Edward R. Annis of Miami was one of the principle speakers at the recent annual meeting of the Florida Hospital Association held at West Palm Beach.

Dr. Leon S. Eisenman of Hialeah has been elected president of the Dade County Academy of General Practice. Dr. Jack Keefe III of Miami has been elected vice president and Dr. Bernard Yesner of Coral Gables, secretary-treasurer.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was one of the principal speakers on the program of the 1959 Blue Shield Professional Relations Conference held the first part of February in Chicago.

A postgraduate course, "The Measurement of Pulmonary Function in Health and Disease," has been scheduled for March 23-27 at the Boston City Hospital in Boston. Co-sponsors are the medical schools of Harvard University, Tufts University, Boston University, the Harvard School of Public Health, Massachusetts Tuberculosis and Health League and the Massachusetts Trudeau Society. Dr. Kip G. Kelso of Vero Beach, president of the Florida Trudeau Society, announcing the course stated that it has been most popular among physicians working in the field of tuberculosis and pulmonary disease since its inception. The tuition fee is $75. Applications may be obtained from Dr. Edward J. Welch, 1101 Beacon Street, Brookline 46, Mass.

The Southwestern Society of Nuclear Medicine will hold its fourth annual meeting at the Roosevelt Hotel in New Orleans March 14-15, according to announcement by Dr. Samuel B. Nadler of New Orleans, chairman of the program committee.

A two day meeting on "Society and the Health of Older People" has been scheduled for March 19-20 by the Institute of Gerontology and the General Extension Division of the University of Florida at Gainesville, according to announcement by Dr. Samuel P. Martin, Professor and Head of the Department of Medicine, College of Medicine, University of Florida. Information on the meeting may be obtained by writing Dr. Robert L. Fairing, 808 Seagle Building, Gainesville.

Dr. Joseph J. Zavertnik of Miami has been installed as president of the Florida Division of

(*Continued on page* 939)

EIGHTY-FIFTH Annual Meeting

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1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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The Southeastern Surgical Congress Assembly, Deauv

Speakers

Monday, March 9

Warren H. Cole, M.D., (Guest), Chicago, Ill., Prof. and Head of Dept. of Surg., Univ. of Ill. College of Medicine
Dissemination of Cancer and Its Prevention

Olof Pearson, M.D., (Guest), New York, N. Y., Assoc. Prof. of Med., Cornell Univ. Med. College
Management of Adrenal Hyperfunction

Robert D. Sloan, M.D., (Guest), Jackson, Miss., Prof. and Chairman, Dept. Radiology, Univ. of Miss. Med. Center
Radiographic Diagnosis of Small Bowel Obstruction — A Statistical Analysis

W. J. Rosser, M.D., Birmingham, Ala., Instr. in Proct., Med. College of Ala.
Anorectal Tuberculosis

Leon Banov, Jr., M.D., Charleston, S. C., Assoc. in Surg. Med. Col. of S. C.
Studies on Healing of Anorectal Wounds

Ernest A. Gould, M.D., Washington, D. C., Chairman, Dept. of General Surg., Washington Hosp. Center
Spontaneous Perforation of the Esophagus as a Complication of Abdominal Surgery

Murray M. Copeland, M.D., Washington, D. C., Prof. and Director of the Dept. of Oncology, Georgetown Univ. Med. Center

PRESIDENTIAL ADDRESS

H. Clinton Davis, M.D., Miami, Fla., Clinical Asst. Prof. of Surg., Univ. of Miami
Inadvertent Primary Resection for the Complications of Sigmoid Diverticulitis

William H. Sewell, M.D., Atlanta, Ga., Instr. in Thoracic Surgery, Emory Univ. Med. School
The Surgical Treatment of Coronary Artery Disease

Robert Lich, Jr., M.D., Louisville, Ky., Prof. and Chairman of the Section on Urology, Univ. of Louisville School of Med.
The Kidney and the Surgeon

Paul W. Sanger, M.D., Charlotte, N. C.
Experience with the Disc Oxygenator in Treatment of Congenital Heart Disease

Oscar Creech, Jr., M.D., New Orleans, La., Prof. and Chairman of Dept. of Surg., Tulane Med. School

Robert Schramel, M.D., New Orleans, La., Asst. Prof. of Surgery, Tulane Med. School

Keith Reemtsma, M.D., New Orleans, La., Asst. Prof. of Surgery, Tulane Med. School
A Critical Evaluation of the Surgical Treatment of Occlusive Peripheral Vascular Disease

R. M. Cunningham, M.D., Baltimore, Md., Instr. in Surg., Univ. of Md. Med. School
Massive Gastrointestinal Bleeding in the Advanced Age Group

Tuesday, March 10

Edward F. Lewison, M.D., (Guest), Baltimore, Md., Asst. Prof. of Surg., Johns Hopkins Univ. School of Med.
The Relationship Between Breast Cancer and Benign Breast Disease

Mark M. Ravitch, M.D., (Guest), Baltimore, Md., Assoc. Prof. of Surg., Johns Hopkins Univ. School of Med. and Surgeon-in-Chief, Baltimore City Hospitals
An Evaluation of Hemipelvectomy

J. R. Heller, M.D., (Guest), Bethesda, Md., Director, National Cancer Institute
Advances Made in Cancer Research

George C. Douglas, M.D., Birmingham, Ala.
Is There a Routine Cervical Smear?

James A. Kirtley Jr., M.D., Nashville, Tenn., Assoc. Pr Clinical Surg., Vanderbilt Univ. Med. School
Report of Results Following Hepatocholangio-jejunosto Roux en Y.

i. Robert Massie, Jr., M.D., Richmond, Va., McGuire Cli and Asst. Prof. of Clinical Surgery, Medical College of Va

Joseph Coxe, III, M.D., Richmond, Va., McGuire Clinic a Asst. Prof. of Clinical Surg., Medical College of Va.
Air Cysts of the Lung

William H. Moretz, M.D., Augusta, Ga., Chairman, Dept. Surg., Med. College of Ga.

C. Martin Rhode, M.D., Augusta, Ga., Clinical Prof. of Su Med. College of Ga.

Mason H. Shepherd, M.D., Augusta, Ga.
Prevention of Pulmonary Emboli by Partial Occlusion the Inferior Vena Cava

W. Coupery Shands, M.D., Jackson, Miss.
Radical Neck Dissection in the Management of Carcino of the Head and Neck

Harwell Wilson, M.D., Memphis, Tenn., Prof. and Chairn of the Dept. of Surg., Univ. of Tenn. Med. School
The Malignant Carcinoid Syndrome: Massive Liver Re tion for Symptomatic Relief

Charles E. Davis, Jr., M.D., Norfolk, Va.
Experiences with Surgical Treatment of Inguinal Hernia the Child

Oscar B. Hunter, Jr., M.D., Washington, D. C., Instr. Hematology, Georgetown Univ. Med. Center
Increasing the Blood Supply by the Use of the Ameri Association of Blood Banks Clearing House Program.

John J. Farrell, M.D., Miami, Fla., Prof. and Chairm Dept. of Surg., Univ. of Miami School of Med.
The Diagnosis and Management of Hyperparathyroidism

William Hopkins, M.D., Atlanta, Ga.
Pleural and Pericardial Biopsy

E. J. Dennis, III, M.D., Charleston, S. C., Asst. Prof. of and Gyn., Med. Col. of S. C.
Preoperative Evaluation of the Patient for Gynecolog Surgery

Francis Bayard Carter, M.D., Durham, N. C., Prof. of and Gyn., Duke Univ. Med. School
The Vaginal Approach for Pelvic Pathologic Problems

Wednesday, March 11

Charles F. Geschickter, M.D., (Guest), Washington, D. Prof. of Pathology, Georgetown Univ. Med. School
Bone Tumors

J. Barrett Brown, M.D., (Guest), St. Louis, Mo., Prof. C cal Surgery, Washington Univ. School of Med., Prof. Ma Iofac Surg., School of Dentistry, Washington Univ. Schoo Med.
Plastic Surgical Principles in Farm, Industrial and Tra Accidents

R. Lee Clark, Jr., M.D., (Guest), Houston, Texas, Prof Surg., Univ. of Texas School of Med.

John S. Stehlin, Jr., M.D., Houston, Texas
Malignant Melanoma; Investigation in Clinical Managem

Edgar W. Davis, M.D., Washington, D. C., Prof. of Thor Surg., Georgetown Univ. Med. Center

Joseph W. Peabody Jr., M.D., Washington, D. C.
Atypical Pain Syndromes Related to Diaphragmatic He

William J. Tobin, M.D., Washington, D. C., Assoc. Prof. thopedic Surg., Georgetown Univ. Med. School
The Relationship of Trauma to Arthritis

John Ashworth, M.D., Baltimore, Md.
Right Lower Quadrant Pain Caused by Adhesions of Colon

Jones W. Lamb, M.D., Greenwood, Miss.

el, Miami Beach, Florida, March 9, 10, 11, 12, 1959

ARL P. BERNET, M.D., Greenwood, Miss.
Endocardial Fibroelastosis

IDORE COHN, JR., M.D., New Orleans, La. Assoc. Prof. of Surgery, La. State Univ. School of Med.
Intestinal Antisepsis

ILLIAM H. MULLER, JR., M.D., Charlottesville, Va., Prof. and Head, Dept. of Surg., Univ. of Va. Med. School
Considerations in Open Heart Surgery

ILLARD H. PARSONS, M.D., Vicksburg, Miss. Chief of Staff and Director of Surg., Vicksburg Hosp. and Clinic, Clinical Assoc. Prof. of Surg., Univ. of Miss.

TUART G. BLACKSHEAR, M.D., Gainesville, Ga., By Invitation

AE SOON LEE, M.D., Vicksburg, Miss., Chief Resident in Surg., Vicksburg Hosp. and Clinic, Instr. in Anatomy, Univ. of Miss. School of Med., By Invitation
Adrenalectomy in the Treatment of Carcinomatosis Subsequent to Carcinoma of the Breast

ILLIAM R. CATE, JR., M.D., Nashville, Tenn., Asst. Prof. of Surg., Vanderbilt Univ. School of Med.
Replacement and By-Pass Grafts in Small Arteries. An Experimental Comparison of Freeze-Dried Arterial Homografts, Autogenous Vein and Crimped Dacron.

RANCIS L. COFFEY, M.D., Huntington, W. Va.
Advances in the Treatment of Carcinoma of the Colon and Rectum

REDERICK E. KREDEL, M.D., Charleston, S. C., Prof. and Head, Dept. of Surg., Med. College of S. C.
Fat Embolism—Clinical and Experimental Studies

ICHARD M. FLEMING, M.D., Miami, Fla., Clinical Prof. of Surg., Univ. of Miami, School of Med., and Director of Surg., Mount Sinai Hosp., Miami Beach, Fla.
Occult Cancer with Clinical Metastases—Rational Approach to Investigation and Management

HARLES C. RUTLEDGE, M.D., Hazard, Ky.
Some Unusual Tumors of the Stomach

Thursday, March 12

OSS Z. PIERPONT, M.D., Baltimore, Md., Assoc. in Surgical Anatomy, Univ. of Md., Asst. in Surgery, Univ. of Md.

ALFRIDO G. FERNANDEZ, M.D., Baltimore, Md.
Inguinal Hernia Repair—A New Concept of the Transversalis Fascia

BRUCE MORTON, II, M.D., Charlottesville, Va., Prof. Clinical Surg. and Gyn., Univ. of Va. Med. School
Some Complications Following Subtotal Gastrectomy

REDERICK SMITH, M.D., Huntsville, Ala.
Cholecystectomy—A Critical Survey of a Personal Series

RTHUR R. NELSON, M.D., Jacksonville, Fla.

LAN KLINE, M.D., Jacksonville, Fla.
Chylous Ascites in Childhood

ICHARD T. HUDSON, M.D., Louisville, Ky., Assoc. Clinical Prof. Orthopedic Surg., Univ. of Louisville Med. School
Disability Evaluation

DWARD R. HIPP, JR., M.D., Charlotte, N. C.
The Surgical Significance of Rib Exostoses

EAL OWENS, M.D., New Orleans, La., Prof. of Surg. (Plastic Surgery), Tulane Univ. of La.
The Common Misconception of "Cosmetic" Surgery

SSE W. CASTLEBERRY, M.D., Orlando, Fla.
Scalene Node Dissections

MES C. THOROUGHMAN, M.D., Atlanta, Ga., Chief of Surg., V. A. Hosp., Associate Prof. of Surg., Emory Univ. School of Med.

OBERT W. PEACE, M.D., Atlanta, Ga., Assoc. Pathologist, Grady Memorial Hosp., Asst. Prof. of Pathology, Emory Univ. School of Med.
Abdominal Surgical Emergencies Caused by Uremic Enterocolitis

ROBERT P. GLOVER, M.D., (Guest), Philadelphia, Pa., Director Thoracic and Cardiovascular Research and Surg., Presbyterian Hosp., Asst. Prof. of Clinical Surg., Univ. of Pa. School of Med.
The Role of the Left Ventricle in Acquired Valvular Hear Surgery

Panel Discussions

Monday, March 9, 4:30 P.M.

TREATMENT OF ADVANCED CANCER OF THE BREAST

Moderator: WARREN COLE, M.D., Chicago, Ill., Prof. and Head of Dept. of Surg., Univ. of Ill. College of Med.

Discussers: EDWARD F. LEWISON, M.D., Baltimore, Md., Asst. Prof. of Surg., Johns Hopkins Med. School
Results of Endocrine Therapy

OLOF H. PEARSON, M.D., New York, N. Y., Assoc. Prof. of Med., Cornell Univ. Med. College
Criteria for Doing Endocrine Gland Ablation—Results

ROBERT D. SLOAN, M.D., Jackson, Miss., Prof. and Chairman, Dept. Radiology, Univ. of Miss. Med. Center
Use of Ionizing Radiations

Tuesday, March 10, 4:30 P.M.

MANAGEMENT OF GYNECOLOGIC PROBLEMS

Moderator: FRANCIS BAYARD CARTER, M.D., Durham, N. C., Prof. Ob. and Gyn., Duke Univ. School of Med.

Discussers: JAMES FERGUSON, M.D., Miami, Fla., Prof. and Chairman of Dept. of Ob. and Gyn., Univ. of Miami School of Med.
Diagnosis

GEORGE C. DOUGLAS, M.D., Birmingham, Ala.
Medical Management

E. J. DENNIS, III, M.D., Charleston, S. C., Asst. Prof. of Ob. and Gyn., Med. College of S. C.
Surgical Management

Wednesday, March 11, 4:30 P.M.

TRAUMA

Moderator: J. D. MARTIN, JR., M.D., Atlanta, Prof. and Chairman, Dept. Surg. Emory Univ. School of Med.

Discussers: WILLIAM H. MULLER, JR., M.D., Charlottesville, Va., Prof. and Chairman, Dept. of Surg., Univ. of Va. School of Med.
Chest and Blood Vessels

HOMER SWANSON, M.D., Atlanta, Ga., Assoc. Prof. Neurosurgery, Emory Univ. School of Med.
Head Trauma

WILLIAM J. TOBIN, M.D., Washington, D. C., Assoc. Prof. Orthopedic Surg., Georgetown Univ. Med. School
Orthopedics

FREDERICK E. KREDEL, M.D., Charleston, S. C., Prof. and Head, Dept. of Surg., Med. School of S. C.
Shock

INFORMATION:

Speakers are listed as nearly as possible as they will appear in the completed program.
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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

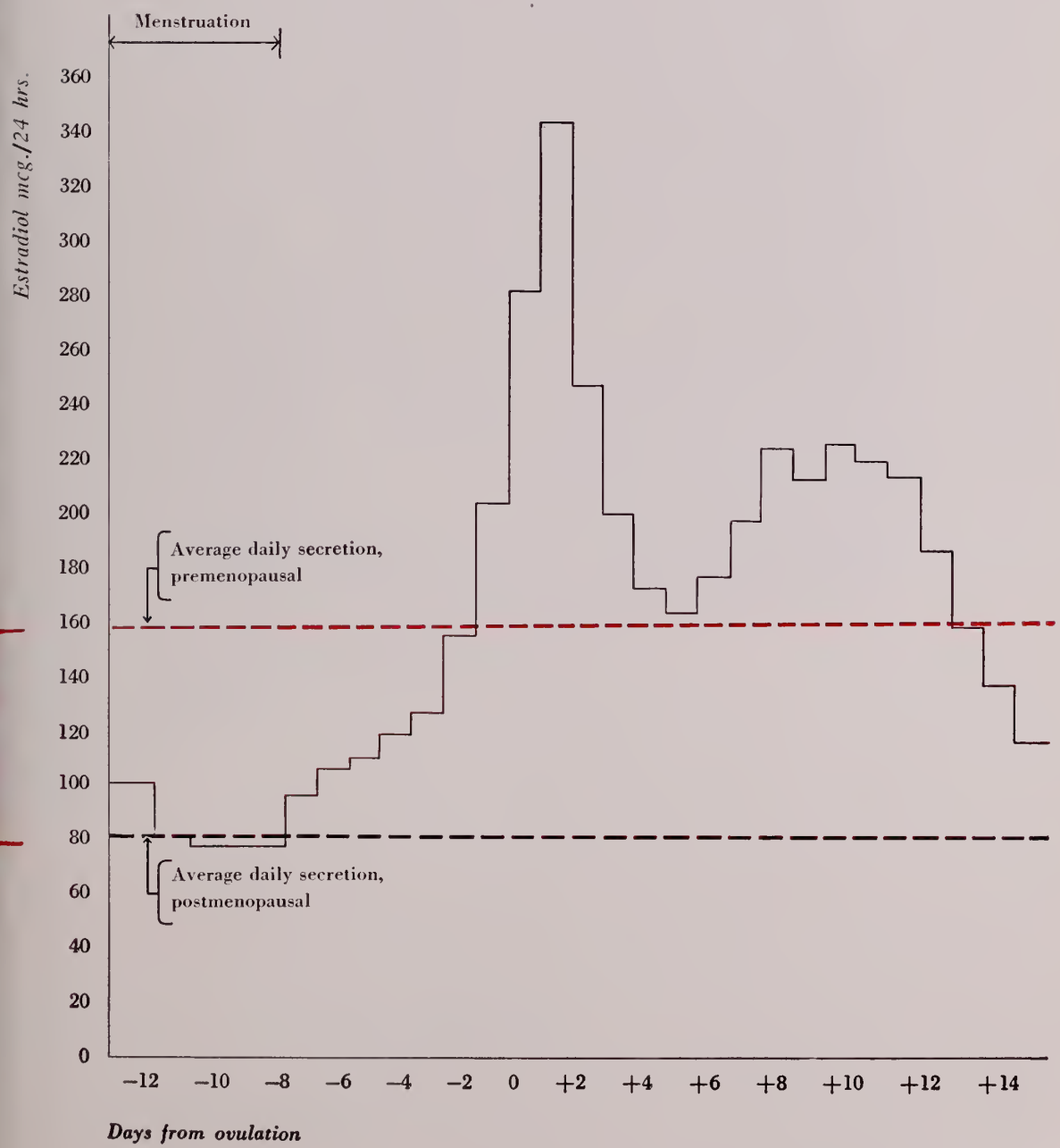
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

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Supplied: Bottles of 100 capsules and 12 oz. of suspension.

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(*Continued from page* 928)

the American Cancer Society. Dr. Harold D. Van Schaick of Jacksonville has been chosen president-elect. Other physicians elected to serve with Drs. Zavertnik and Van Schaick include Dr. Dale E. York of Pensacola, first vice president, and Dr. Earl E. Wilkison of Tallahassee, third vice president.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, was one of the principal speakers on the program for the meeting of the Florida Division, American Cancer Society, held recently at West Palm Beach.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, participated in the panel on the program of the First Regional Institute on Cardio-vascular Rehabilitation sponsored by the Hillsborough County Heart Association in Tampa early in December.

Drs. George S. Palmer and Francis T. Holland both of Tallahassee will officially represent the Florida Medical Association at the Florida Congress of Parents and Teachers being held in Tallahassee February 18-19.

Dr. Duncan T. McEwan of Orlando was one of the principal speakers on the program of the January meeting of the Sarasota County Medical Society held at Sarasota. Other participants included Drs. John M. Butcher and Millard B. White both of Sarasota.

Dr. Claude G. Mentzer of Miami has been elected president of the Florida Chapter of the International College of Surgeons. Dr. Alfred G. Levin of Miami has been elected vice president and Dr. Herbert W. Virgin Jr. also of Miami secretary-treasurer. Dr. Don C. Robertson of Orlando has been re-elected regent for Florida. Vice regents include Dr. John J. Lovejoy of Jacksonville.

The photograph of Dr. John P. Wall of Tampa, President of the Florida Medical Association in 1884, has been obtained through the efforts of Dr. William M. Rowlett of Tampa and has been hung with the photographs of other past presidents in the headquarters building of the Association in Jacksonville.

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SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®

(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.

2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.

3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.

4. J. A. M. A., 167:1584, July 26, 1958.

5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.

6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.

7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.

8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.

9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.

10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

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Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
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Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

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COMPONENT SOCIETY NOTES

Bay

Dr. James D. Nixon has been elected president of the Bay County Medical Society for the year 1959. Serving with Dr. Nixon will be Dr. John J. Hollman Jr., as vice president; Dr. Robert L. Overman, as secretary, and Dr. Charles H. Daffin as treasurer. All are from Panama City.

Brevard

Dr. Louis C. Jensen Jr., of Rockledge, has been elevated from vice president to president of the Brevard County Medical Society. Dr. Carl J. Arnold Jr., of Cocoa, has been elected secretary-treasurer.

Collier

Dr. John J. Meli has been elected president of the Collier County Medical Society. He served the Society last year as vice president. Dr. Loral F. Gwaltney, who served as treasurer last year, has been chosen vice president. Dr. William J. Bailey has been elected treasurer, and Dr. Ethel H. Trygstad has been re-elected secretary. All are from Naples.

Columbia

Dr. Harry S. Howell is serving as president of the Columbia County Medical Society following his election at the recent annual meeting. Dr. Howell was formerly vice president. Dr. Louis G. Landrum has been elected vice president after serving last year as secretary-treasurer. Dr. Thomas H. Bates succeeded Dr. Landrum as secretary-treasurer. Drs. Howell, Landrum and Bates are from Lake City.

Dade

Dr. Robert P. Keiser, of Coral Gables, has been installed as president of the Dade County Medical Association. Chosen president-elect at the recent annual meeting was Dr. Franklin J. Evans, also of Coral Gables, who served last year as vice president. Other newly elected officers include Dr. George W. Robertson, of Miami, vice president; Dr. DeWitt C. Daughtry, of Miami, secretary, and Dr. Francis N. Cooke, of Miami, treasurer. Dr. Robertson was formerly secretary, and Dr. Cooke was re-elected.

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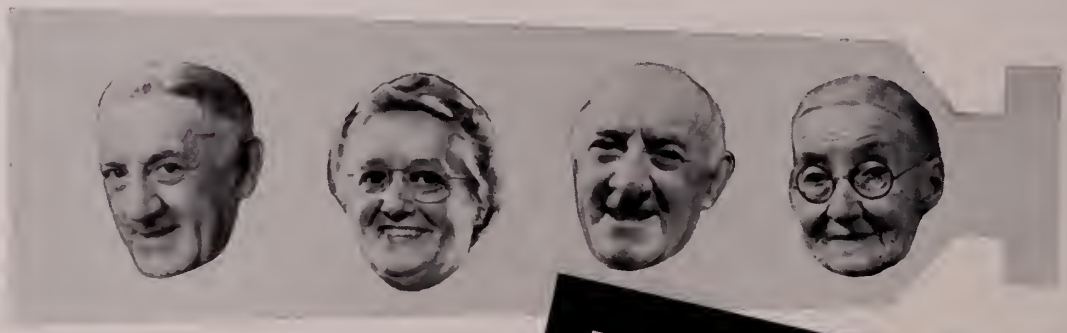
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County Medical Society. Other officers chosen to serve with Dr. Smith for the year 1959 are Dr. Merle C. Kayton as vice president, and Dr. Miles A. Collier as secretary-treasurer. All are from Wauchula.

Duval

Dr. Samuel M. Day has been installed as president of the Duval County Medical Society. Dr. Floyd K. Hurt has been chosen as president-elect. Elected at the recent annual meeting to serve with Drs. Day and Hurt were Dr. Gordon H. Ira as vice president, Dr. Ray O. Edwards Jr. as secretary, and re-elected was Dr. Sidney Stillman as treasurer. All are from Jacksonville.

Escambia

Dr. Egbert V. Anderson has begun serving as president of the Escambia County Medical Society following installation ceremonies at the Society's annual meeting. Dr. William J. Overman, of Warrington, president-elect, Dr. Joseph L. Rubel, vice president, and Dr. Joseph Q. Perry, secretary-treasurer, are the other new officers who will be serving during 1959. Dr. Perry was re-elected. He, Dr. Rubel and Dr. Anderson are from Pensacola.

Hillsborough

Dr. Harold G. Nix, who served as president-elect during 1958, has been installed president of the Hillsborough County Medical Association. Dr. Linus W. Hewitt has been chosen president-elect. First vice president is Dr. James A. Winslow, elevated from secretary, and second vice president is Dr. Hugh G. Steele. Dr. Collin F. Baker Jr. is the newly elected secretary, and Dr. Marvin B. Miller remains as treasurer. All are from Tampa.

Jackson-Calhoun

Dr. Glenn E. Padgett, who served as vice president last year, has been elected president of the Jackson-Calhoun County Medical Society. Dr. Courtland D. Whitaker fills the position of vice president. Dr. Francis M. Watson has been re-elected secretary-treasurer. All are from Marianna.

Lake

Dr. Frederick C. Andrews, of Mount Dora, has been elected president of the Lake County Medical Society after having served as secretary-treasurer last year. Dr. Lawton F. Douglass, of

(*Continued on page* 951)

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

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Otamylon is a clear, odorless, sterile, viscid liquid containing:
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DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
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Hyoscine hydrobromide	0.0065 mg.
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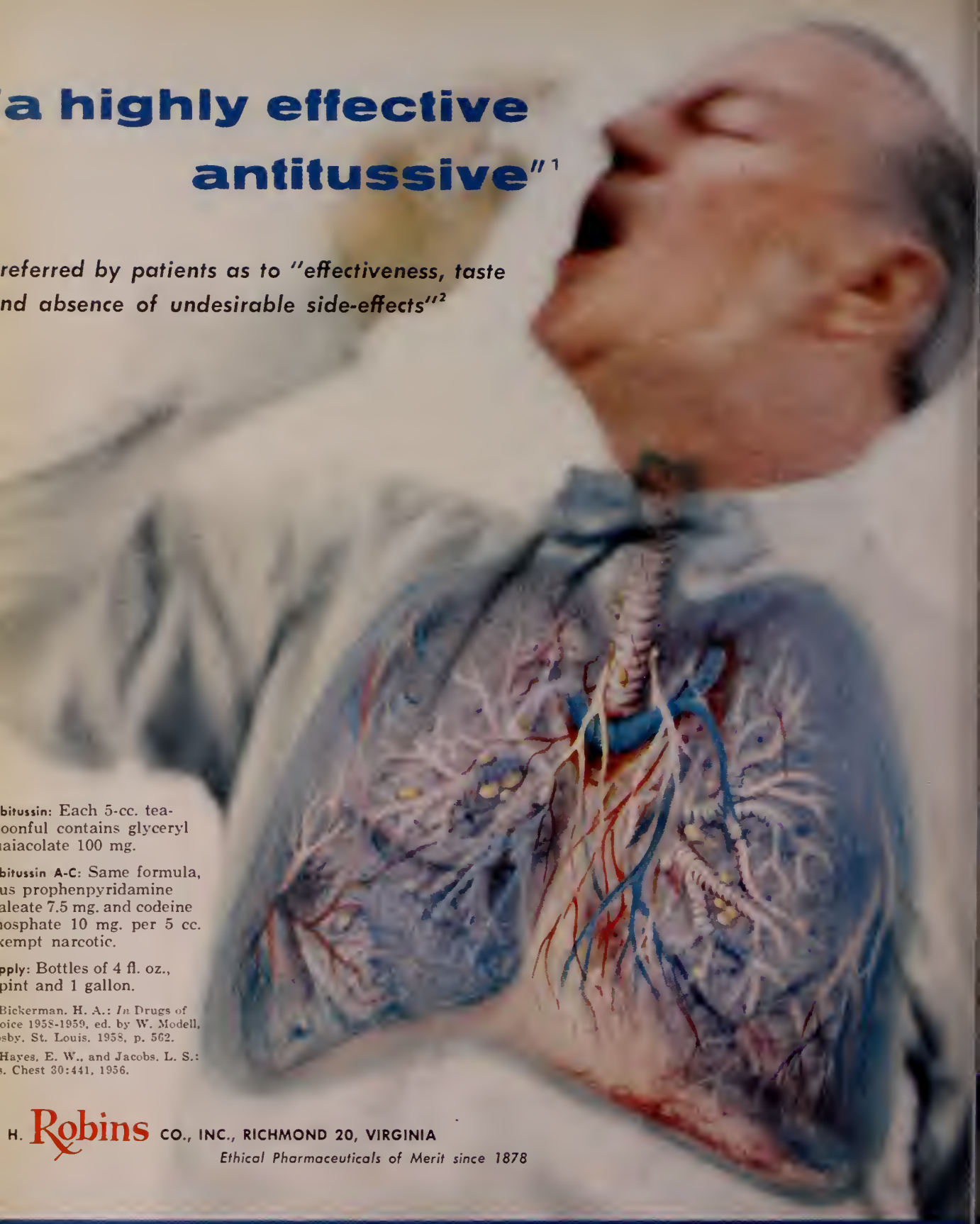
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Bickerman, H. A.: *In* Drugs of oice 1958-1959, ed. by W. Modell, osby, St. Louis, 1958, p. 562.

Hayes, E. W., and Jacobs, L. S.: s. Chest 30:441, 1956.

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(*Continued from page* 947)

Umatilla, has been re-elected vice president, and Dr. Thomas D. Weaver, of Clermont, has been chosen secretary-treasurer.

Lee-Charlotte-Hendry

Dr. Wilson A. Rumberger has been elected president of the Lee-Charlotte-Hendry County Medical Society. Dr. Gustave F. Bieber has been chosen as vice president, and Dr. James C. Carver as secretary-treasurer. All are from Ft. Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Hilliard R. Reddick, of Quincy, has been elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Edson J. Andrews, of Tallahassee, will serve with Dr. Reddick as vice president. and Dr. Nelson H. Kraeft as secrtary-treasurer. Dr. Kraeft, of Tallahassee, was re-elected.

Manatee

Dr. Irving E. Hall Jr. has been elected president of the Manatee County Medical Society after having served last year as secretary-treasurer. Dr. John A. Shively is the Society's new vice president. Serving with Drs. Hall and Shively is Dr. Joseph E. Duke as secretary-treasurer. The officers are from Bradenton.

Marion

Dr. Earl E. Yantis has been installed as president of the Marion County Medical Society. Installed with Dr. Yantis were Dr. Robert L. Gibson as vice president and Dr. Wallace E. Winter as secretary-treasurer. Drs. Yantis, Gibson and Winter are from Ocala.

Monroe

Dr. Joseph J. Scarlet has been elected president of the Monroe County Medical Society. Dr. Scarlet served as secretary-treasurer during 1957 and as vice president last year. Dr. Walter R. McCook, who served as secretary-treasurer during 1958, has been elected vice president, and Dr. Herman K. Moore as secretary-treasurer. All are from Key West.

Nassau

Dr. David D. Bennett Jr., of Callahan, has been elevated from secretary-treasurer to president of the Nassau County Medical Society. Dr. Henry B. Dickens Jr. has been elected vice presi-

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dent, and Dr. Cecil B. Brewton secretary-treasurer. Drs. Dickens and Brewton are from Fernandina Beach.

Orange

Dr. Robert L. Tolle has been installed as president of the Orange County Medical Society. Chosen president-elect at the Society's recent annual meeting was Dr. W. Dean Steward who will assume the duties of president at the end of 1959. Dr. Benjamin Glaser, who served as reporter last year, has been elected vice president. Dr. Robert W. Curry, secretary, and Dr. Charles R. Sias, treasurer, have been re-elected. Dr. Frederick E. Medlock Jr. has been chosen as reporter. All are from Orlando.

Palm Beach

Dr. Younger A. Staton, of West Palm Beach, has begun serving as president of the Palm Beach County Medical Society following installation ceremonies at the Society's recent annual meeting. Dr. Willard F. Ande, also of West Palm Beach, who served as treasurer last year, has been chosen president-elect to take office at the end of 1959. Other officers include Dr. Lorenzo James vice president; Dr. Herman Baxt secretary, and Dr. William H. Proctor treasurer. Drs. James, Baxt and Proctor are from West Palm Beach.

Pasco-Hernando-Citrus

Dr. Alfred G. Brown Jr., of Inverness, has been elected president of the Pasco-Hernando-Citrus County Medical Society. He served as a vice president last year. Drs. Richard A. Henry, of Brooksville, and William H. Walters Jr., of Lacoochee, will serve with Dr. Brown as vice presidents. Dr. W. Wardlaw Jones, of Dade City, was re-elected secretary-treasurer.

Pinellas

Dr. Rowland E. Wood, of St. Petersburg, has been installed as president of the Pinellas County Medical Society, and Dr. Chas. L. Farrington, also of St. Petersburg, has been elected president-elect. Serving with Drs. Wood and Farrington this year will be Dr. Thomasson P. Dann, of St. Petersburg, first vice president; Dr. Claude G. Hooten Jr., of Clearwater, second vice president, and Dr. Whitman C. McConnell, of St. Petersburg, secretary-treasurer. Dr. McConnell was re-elected.

(*Continued on page* 964)

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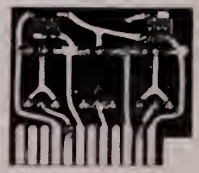
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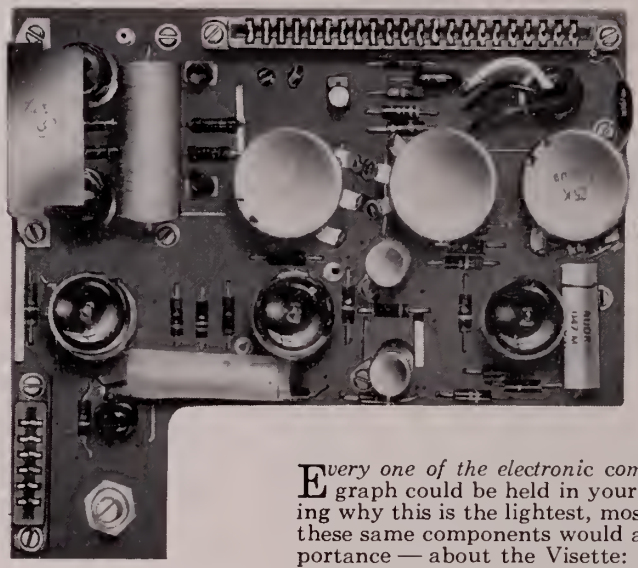
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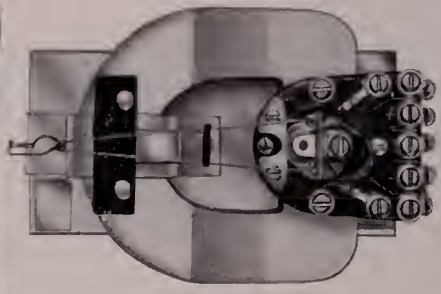
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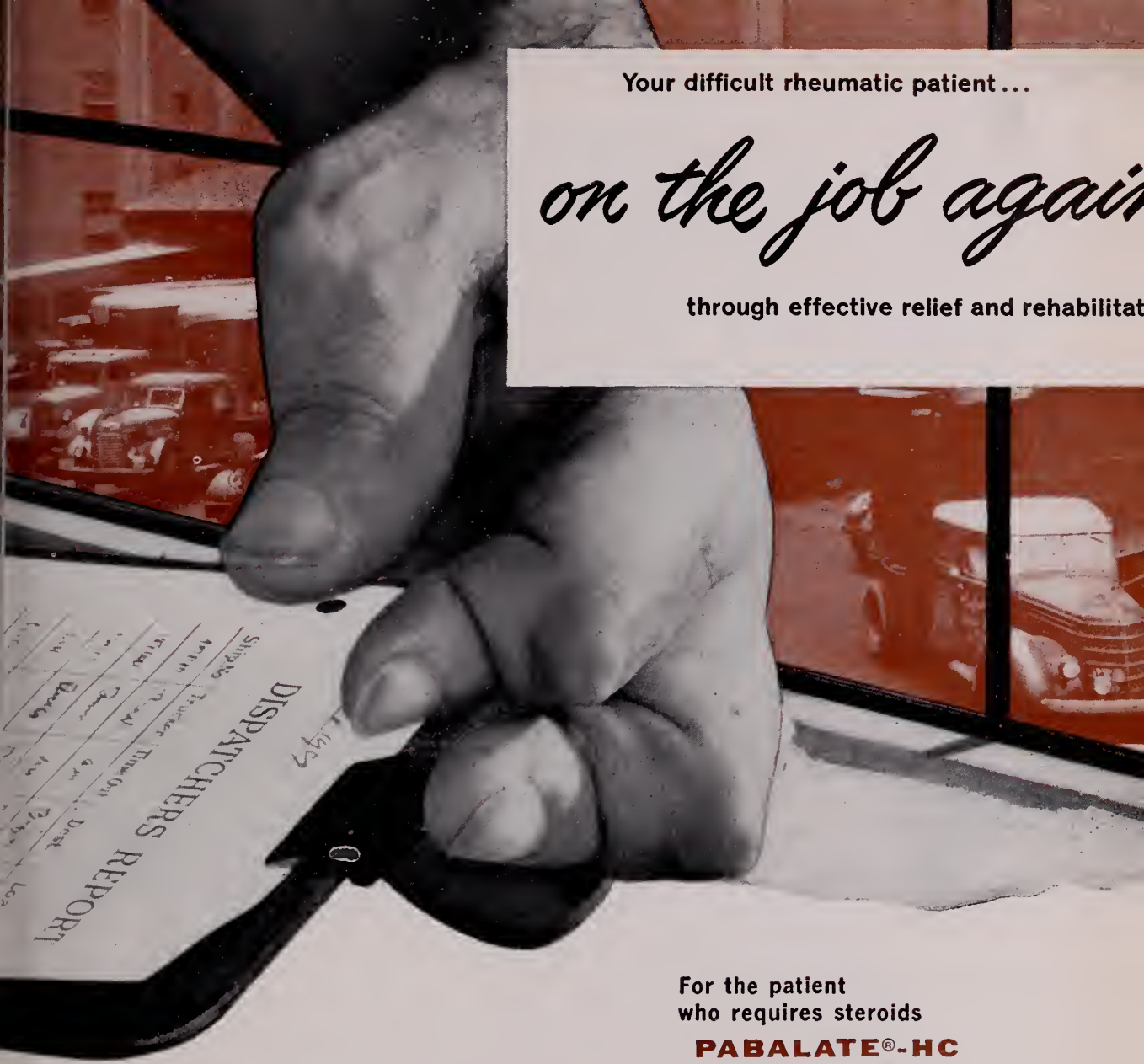
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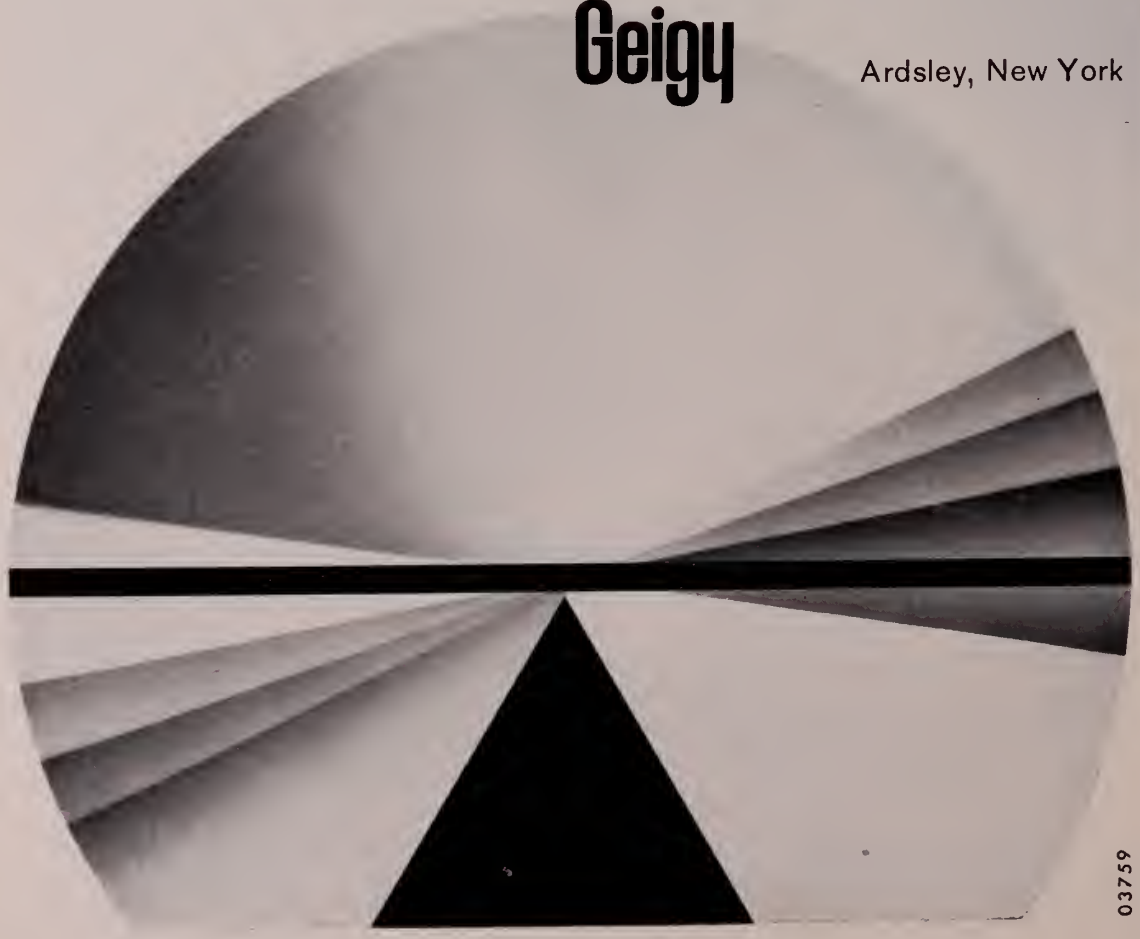
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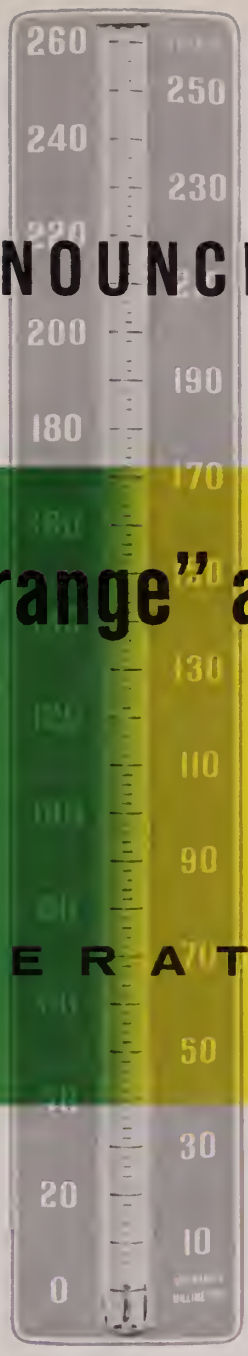
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ANNOUNCING

the first "wide range" antihypertensive

MILD MODERATE SEVERE

DIUPRES*

DIURIL® WITH RESERPINE

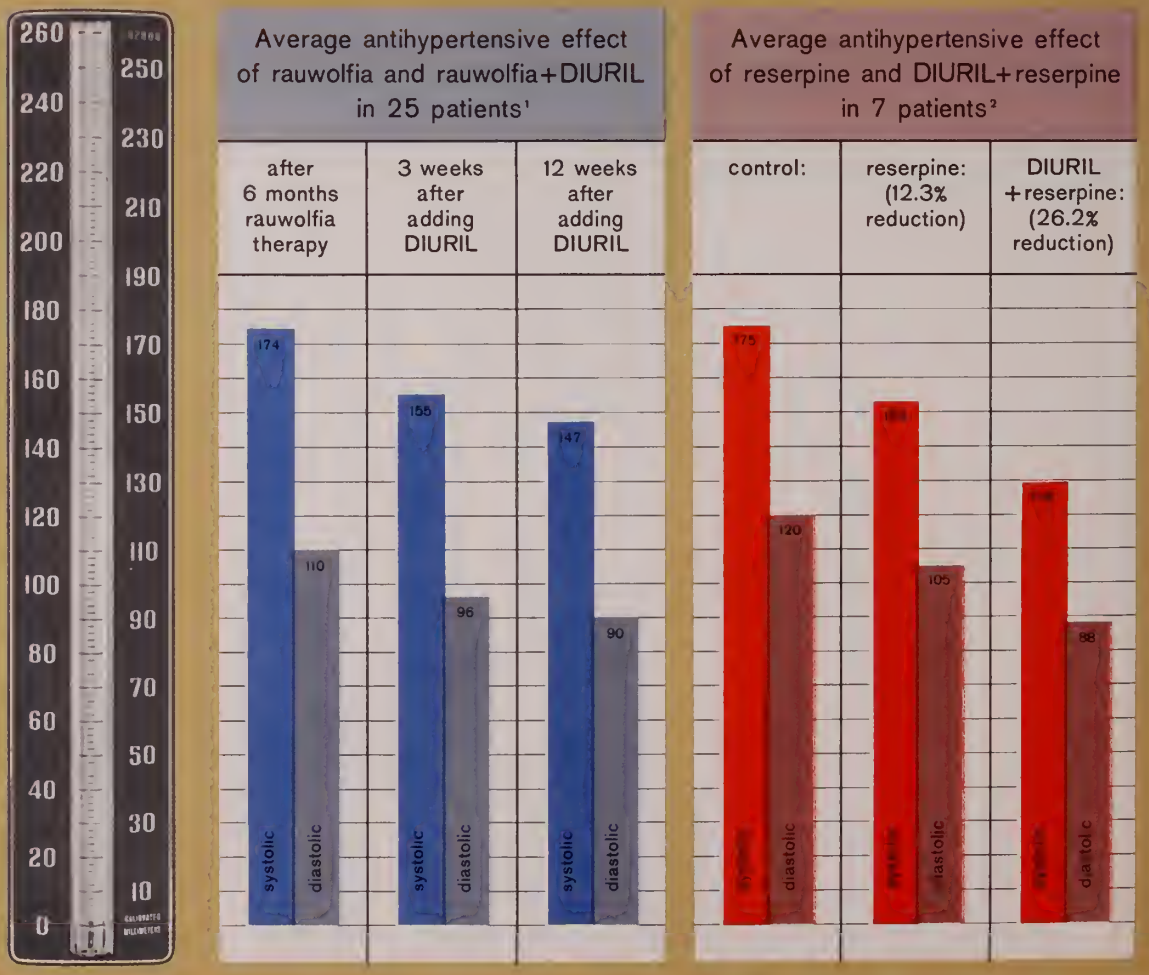
more hypertensives can be better controlled
with DIUPRES than with any other agent
. . . with greater simplicity and convenience

a logical alliance of two antihypertensives
you know and trust provides

increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.



DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

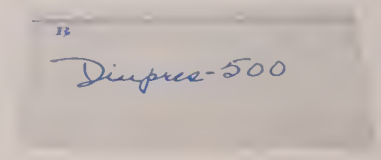
Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

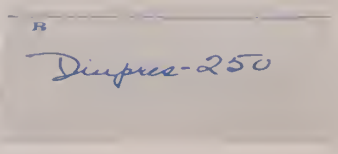
DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.



DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

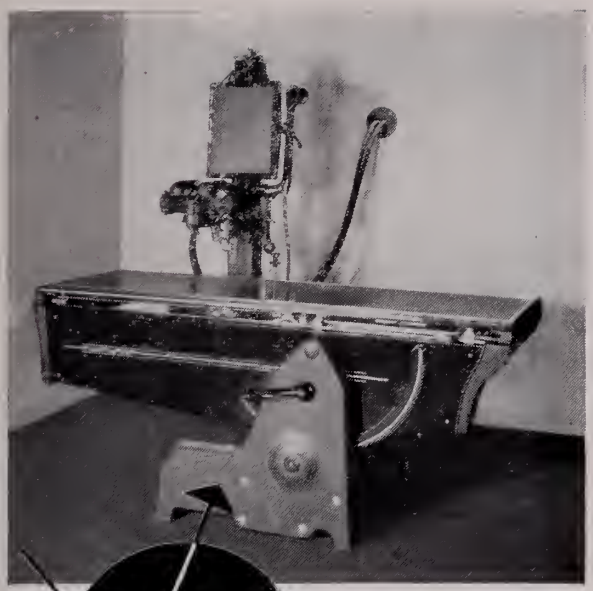
DIUPRES

DIURIL® WITH RESERPINE

1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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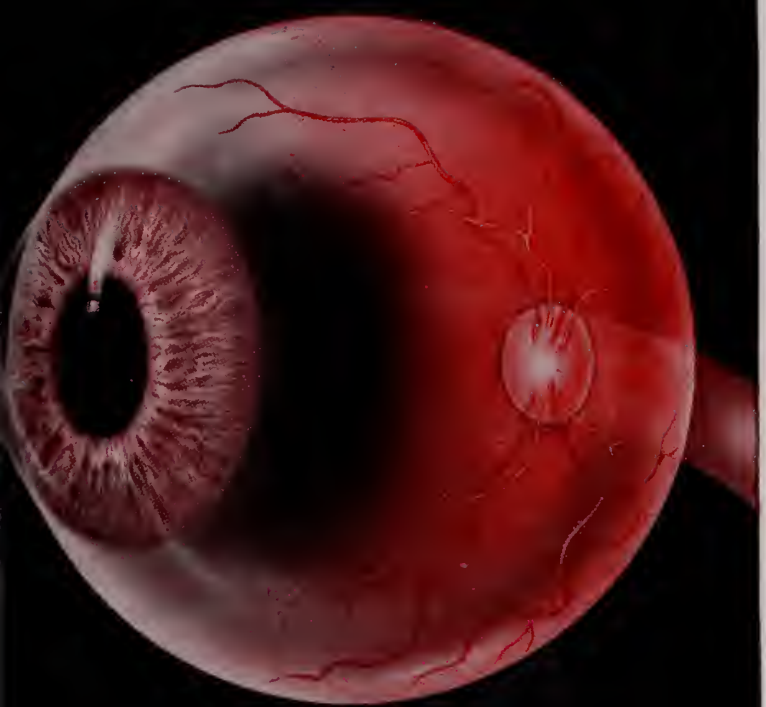
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RATIONALE

"It appears that there is now available in chlorothiazide a drug which is a specific antagonist to the abnormal sodium metabolism seen in the vast majority of hypertensive patients. The use of this agent [DIURIL] may stand the test of time as the most vital and specific weapon in the treatment of a relatively non-specific disease in which the only specific abnormality known is one of sodium metabolism. . . . Chlorothiazide now appears to be the drug of choice when initiating therapy in the average hypertensive patient."

Reinhardt, D. J.:
Delaware State Med. J. 30:1, January 1958.

RESULTS

"We have presented a group of 48 patients previously treated with a variety of antihypertensive agents." "Upon the addition of chlorothiazide to their regimens, there was realized an additional blood pressure lowering effect of 23 mm. systolic and 11 mm. diastolic."

Bunn, W. H., Jr.:
Ohio State Med. J. 54:1168, September 1958.

MINIMAL SIDE EFFECTS

"There is an extremely wide range between therapeutic and toxic dosage, and no significant side effects and no sensitivity to the drug as yet have been observed."
". . . it seems desirable to add potassium chloride 4 Gm. per day . . . in cases of hypertension. . . ."

Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:
Texas State J. Med. 54:639, September 1958.

dosage: one 250 mg. tablet DIURIL b.i.d. to one 500 mg. tablet DIURIL t.i.d.

supplied: 250 mg. and 500 mg. scored tablets DIURIL (Chlorothiazide) bottles of 100 and 1000.

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(Erythromycin Stearate, Abbott)

an uncommon antibiotic for common infections

after millions of prescriptions ...an unparalleled safety record

provides fast, high blood and tissue concentrations

Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes. High, peak levels occur between one and two hours—and effective concentrations are maintained for at least six hours. Always at hand, then, against more critical infections is ERYTHROCIN-I.M.—the only intramuscular form of erythromycin available.

backed by years of clinical effectiveness

Actually, every prescription you write for ERYTHROCIN is backed by more than six years of clinical effectiveness against coccal infections. And, with the problem of antibiotic resistance becoming more important daily, the value of ERYTHROCIN as a day-to-day anticoccal agent is dramatically underlined.

supported by an unparalleled safety record

During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad-spectrum" action, the normal flora of the intestinal tract is virtually unaltered with ERYTHROCIN therapy.

offers bactericidal activity

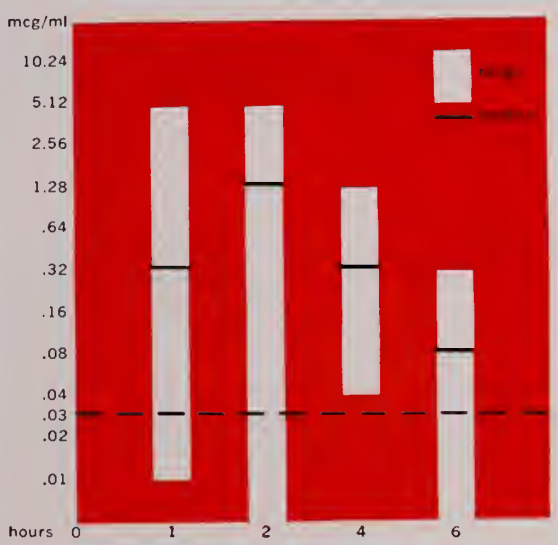
Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal antibiotic. It offers lethal action against common coccic invaders—resulting in prompt clinical response.

provides convenient dosage forms

Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also in oral suspension and for intramuscular use. Won't you prescribe ERYTHROCIN doctor? Abbott

if you're concerned with blood levels...

Dotted line shows actual inhibitory concentrations against most organisms. Note the high ranges and medians of ERYTHROCIN Stearate at one, two, four and six hours. Data represents three studies with adults. Each was given one 250-mg. Filmtab.



And where you need a consistent uniform response that only an injectable form can provide, remember—**ERYTHROCIN-I.M.**(Erythromycin Ethyl Succinate, Abbott) and **ERYTHROCIN LACTOBIONATE.**

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.

(*Continued from page* 952)

Polk

Dr. Newell J. Griffith, of Winter Haven, has been installed as president of the Polk County Medical Association after having served as president-elect last year. Chosen president-elect at the recent annual meeting was Dr. Charles Larsen Jr., of Lakeland, who served last year as secretary-treasurer. Dr. Edgar B. Hodge, of Lake Alfred, has been elected vice president, and Dr. Clarence L. Anderson, of Lakeland, secretary-treasurer.

St. Lucie-Okeechobee-Martin

Dr. Robert F. Meeko, of Ft. Pierce, has been elected president of the St. Lucie-Okeechobee-Martin County Medical Society. Dr. Maltby F. Watkins, also of Ft. Pierce, has been re-elected secretary-treasurer.

St. Johns

Dr. William J. Gibson has been elected president of the St. Johns County Medical Society. Serving with Dr. Gibson will be Dr. Reddin Britt as vice president; Dr. Joseph A. Shelley as secretary, and Dr. Reuben J. Plant Jr. as treasurer. All are from St. Augustine.

Sarasota

Dr. Andrew J. Jesacher has been installed as president of the Sarasota County Medical Society, and Dr. James E. Kicklighter has been chosen president-elect after serving the Society last year as secretary. Dr. George A. Bishopric has been elected secretary, and Dr. Millard E. White has been re-elected treasurer. The officers are from Sarasota.

Volusia

Dr. Alphonsus M. McCarthy has been installed as president of the Volusia County Medical Society. Dr. James J. Cunningham, of New Smyrna Beach, has been elected president-elect. Chosen to serve with Drs. McCarthy and Cunningham were Dr. John J. Cheleden as secretary, and Dr. Rollin P. Fiero as treasurer. Drs. McCarthy, Cheleden and Fiero are from Daytona Beach.

Walton-Okaloosa-Santa Rosa

Dr. John C. Holley, of Milton, has been elected president of the Walton-Okaloosa-Santa Rosa County Medical Society. Dr. Eric F. Geiger, also of Milton, has been chosen vice president, and Dr. Wm. W. Thompson, of Ft. Walton Beach, has been elected secretary-treasurer.

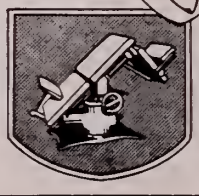


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AND 100 MG. WITH 100 MG. CITRIC ACID.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Adel, Frank E., Lake City
Alexander, Bronson R., St. Petersburg
Alley, John C., Miami
Allison, Joseph, N. Miami Beach
Beeler, Robert V., Sarasota
Burns, F. J. Jr., St. Petersburg
Cahoon, Stuart N., Miami
Faizo, Frank V., St. Petersburg
Grogan, Robert E., Jupiter
Jones, David L., St. Petersburg
Jones, James R. Jr., Orlando
Keeler, William H. III, St. Petersburg
Kimmel, Bernard, W. Palm Beach
Lampkin, John C., W. Palm Beach
McAndrew, John J., Orlando
O'Neill, James F., St. Petersburg
Poteete, Floyd H. Jr., Pahokee
Reese, Norman O., Jacksonville
Robinson, Alan S., Coral Gables
Schultz, J., St. Petersburg Beach
Strahan, N. A., Opa Locka
Tannozzini, Joseph R., N. Miami
Williams, Jean B., Jacksonville
Wills, Silas A., Jacksonville
Youmans, Julian R., St. Petersburg
Yount, Harold A., W. Palm Beach

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Robert A. Shashy of Jacksonville announce the birth of a son, Robert Charles, on Oct. 19, 1958.

Dr. and Mrs. Albert D. Rood of Jacksonville announce the birth of a daughter, Lori Elizabeth, on Nov. 21, 1958.

Dr. and Mrs. Virgilio B. De Padua of Jacksonville announce the birth of a daughter, Patricia Garcia, on Oct. 17, 1958.

Marriage

Dr. Richard P. Thompson of Jacksonville and Miss Mary Ursula Jones were married on Nov. 29, 1958.

Deaths — Other Doctors

Herbert, William, Dunedin ..... September 26, 1958
Rauch, Harvey Milton, Ormond Beach ... October 1, 1958

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All of our products are Laboratory analyzed.

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Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

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'EMPIRIN' COMPOUND®

WITH

CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations



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Symbols OF PROVEN PAIN RELIEF



gr. 1



gr. ½



gr. ¼



gr. ⅛

Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*



Codeine Phosphate . . . . . gr. ½
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

'CODEMPIRAL'® NO. 2*



Codeine Phosphate . . . . . gr. ¼
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

'TABLOID'

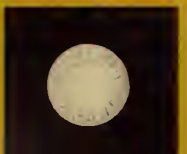
'EMPIRIN' COMPOUND®



Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½
Caffeine . . . . . gr. ½

...from mild pain complicated by tension and restlessness.

'EMPIRAL'®



Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

*Subject to Federal Narcotic Regulations



new 3-way build-up for the under par child...

Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate...plus sorbitol for enhanced absorption of both iron and B_{12}.

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delicious cherry flavor—no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

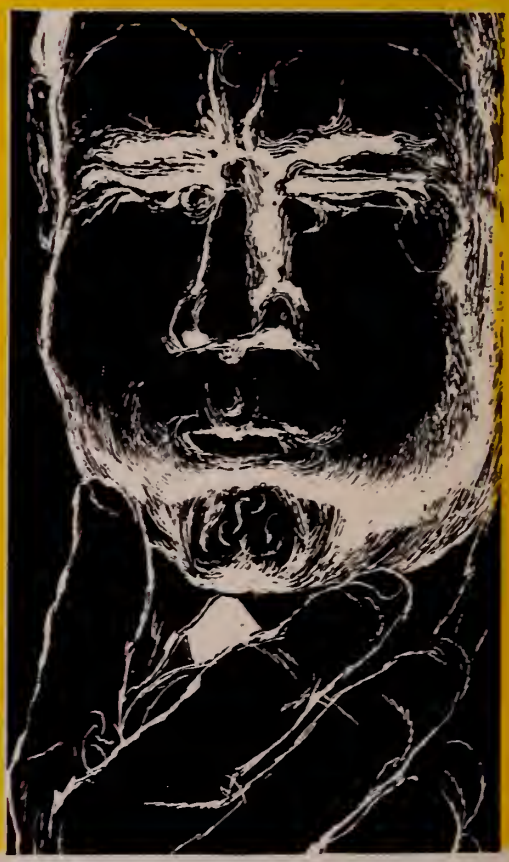
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(POTASSIUM PENICILLIN V)

INDICATIONS

Against all penicillin-sensitive organisms. When combined with Sulfas, COMPOCILLIN-VK is especially effective in treating mixed infections such as may occur in the respiratory or urinary tract.

DOSAGE

Range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. Children's dosage is determined by body weight. When combined with sulfa triad, range is one Filmtab three times daily to two Filmtabs every four hours.

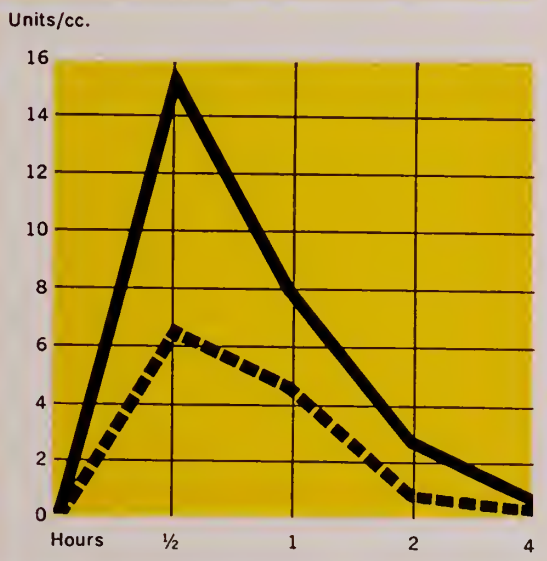
SUPPLIED

COMPOCILLIN-VK Filmtabs: 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100.

COMPOCILLIN-VK Granules for Oral Solution: In 40-cc. and 80-cc. bottles. When reconstituted, each tasty 5-cc. teaspoonful of cherry-flavored solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-VK with Sulfas: Each Filmtab contains 125 mg. (200,000 units) of potassium penicillin V and 500 mg. of sulfonamides. At all pharmacies.

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The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

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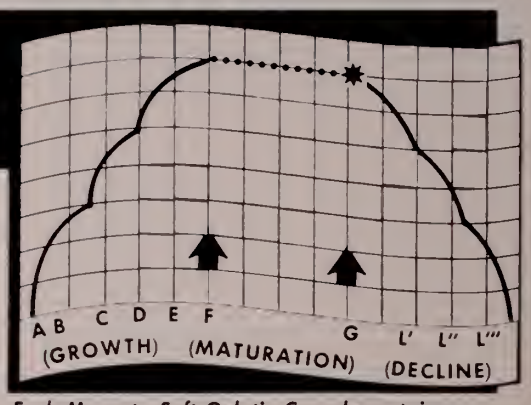
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Members Wanted: Hundreds acceptable
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Qualifications: Doctors' wives. No previous experience necessary.
Permanent position. Benefits unlimited.
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Jobs available immediately. Transportation no problem.
Show the world that you stand side by side with your husband.
Every physician's wife has a contribution to make
Every physician's wife is wanted
Every physician's wife is needed
Be a Member of The Team—Join!

Mrs. Albert F. Stratton Jr.

...to postpone the "G" point*...

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For patients over 40, The G POINT (point of declination in life) can be postponed!

Properly balanced Androgen — Estrogen — nutritional therapy may prevent premature aging and damage of gonadal decline and nutritional inadequacy.

Complaints of symptoms such as muscular pain, fatigue, irritability, and poor appetite in the patient over 40 may be the first indications of three major stress factors in the aging process: (1) Gonadal Hormonal Imbalance, (2) Nutritional Inadequacy and (3) Emotional Instability. GERITAG is especially formulated to guard against premature damage and to delay the degenerative process.

Rx GERITAG in preventive geriatrics.

Each Magenta Soft Gelatin Capsule contains:

Methyltestosterone	2 mg.	Thiomine Hcl.	2 mg.
Ethinyl Estradiol	0.01 mg.	Riboflavin	2 mg.
Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg	Niacinomide	20 mg.
Ascorbic Acid	30 mg.	Mangonese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0 15 mg.
Cobalt	0.1 mg.	Potossium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
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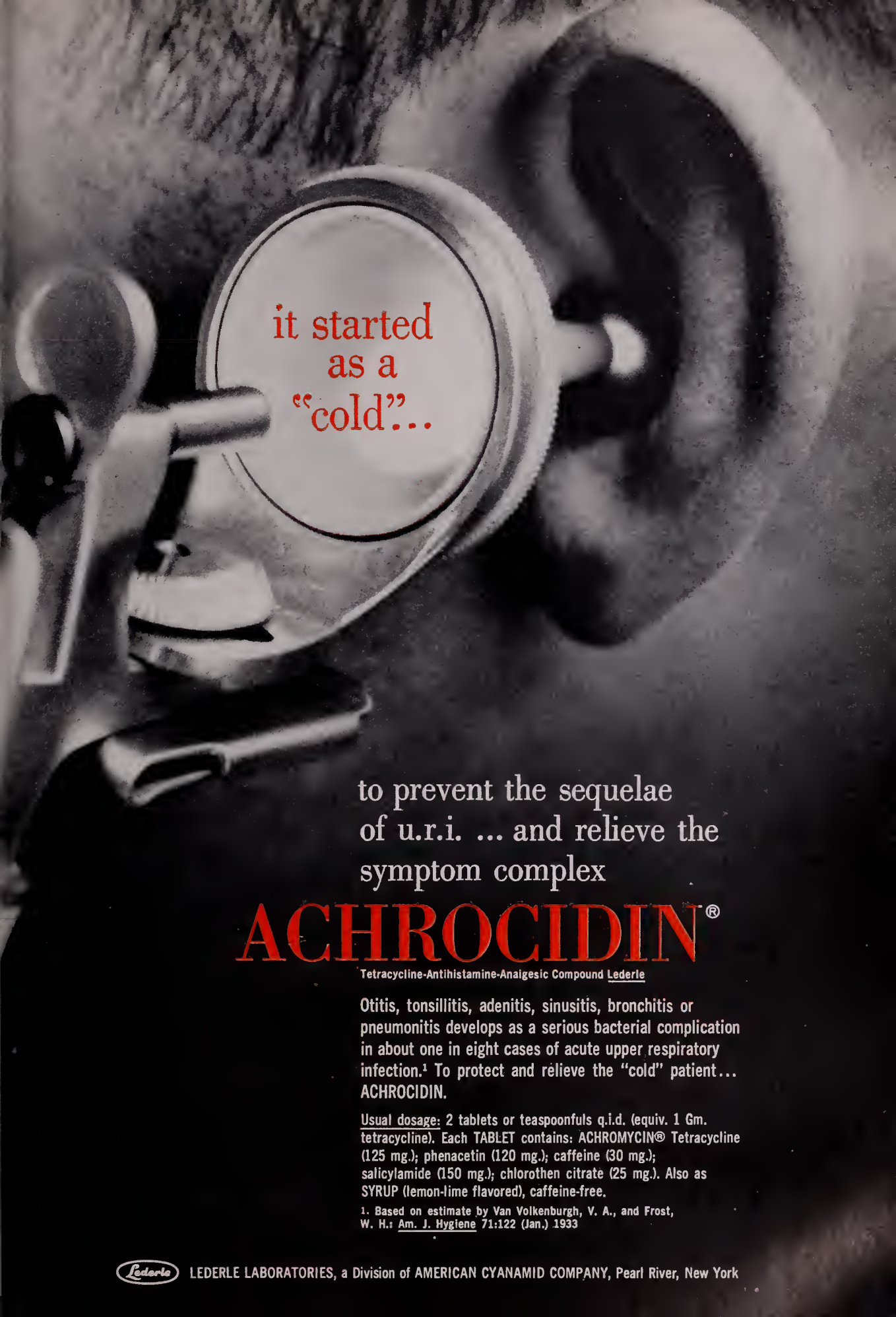
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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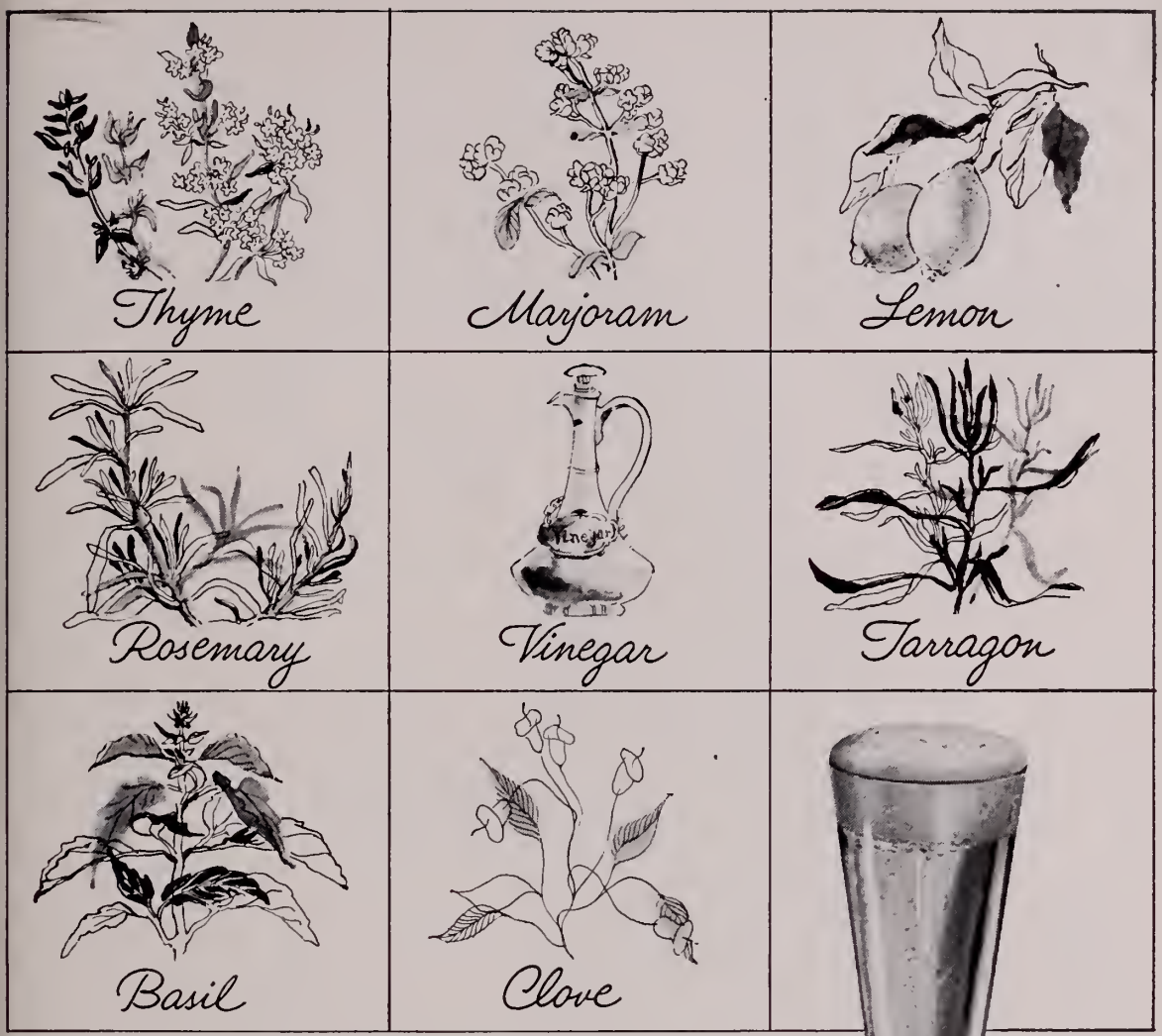
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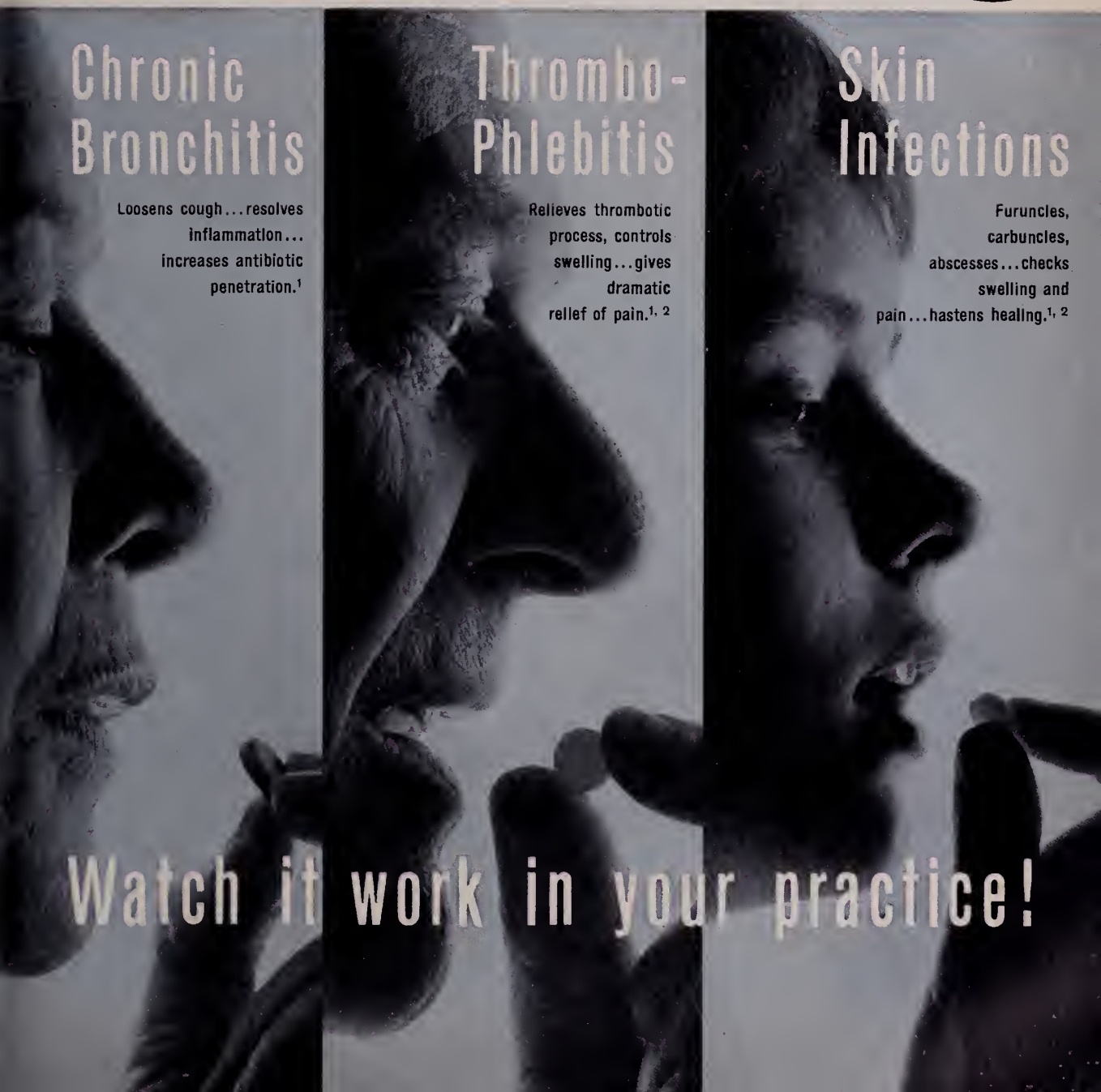
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BOOKS RECEIVED

Orr's Operations of General Surgery. By George A. Higgins, M.D., F.A.C.S., and Thomas G. Orr, Jr., M.D., F.A.C.S. Ed. 3. Pp. 1016. Illus. 835. Price, $20.00. Philadelphia, W. B. Saunders Company, 1958.

This valuable reference for the practicing surgeon gives both new and long-established technics of proved merit for operations on the entire body—from excision of an ingrown toenail to surgical division of patent ductus arteriosus. To this new third edition hundreds of new illustrations have been added. New operations and other new material bring the book right in line with today's surgery. Indications, dangers and safeguards, and step-by-step technic are all clearly presented. Although comprised chiefly of surgical technics, a volume such as this should be useful to medical students, interns and residents as well as to the practicing surgeon. General practitioners, internists and other members of the medical profession who do little or no operative surgery will find this a valuable aid in understanding the nature, scope, and limitations of surgical procedures recommended for their patients.

Chronic Bronchitis, Emphysema and Cor Pulmonale. By C. H. Stuart-Harris, M.D. (Lond.), F.R.C.P., and T. Hanley, M.D. (Lond.), M.R.C.P. Pp. 245. Price, $8.50. Bristol, John Wright & Sons Ltd., 1957. (The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.)

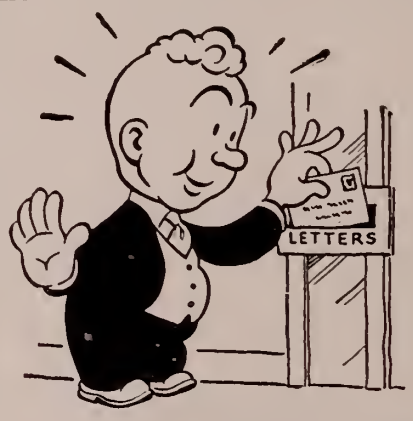
The subjects dealt with in this monograph, primarily written for clinicians, are common ailments known to them for centuries. They represent a considerable proportion of the diseases of the chest met with in general practice and in the medical work of hospitals in all parts of Great Britain. The extensive research described in the 11 chapters of the book covers the definition, clinical picture, exacerbations, terminal illness and morbid anatomy of chronic bronchitis, the differential diagnosis of chronic bronchitis, infection and its relation to chronic bronchitis and emphysema, emphysema and the function of the lungs, emphysema, pulmonary heart failure, the pathologic physiology of cor pulmonale, treatment, and the epidemiology and pathogenesis of chronic bronchitis.

Medical Electrical Equipment. *Principles, Installation, Operation and Maintenance of Electrical Equipment used in Hospitals and Clinics.* Advisory Editor, Robert E. Molloy, M.B., F.F.A., R.C.S., Pp. 312. Illus. 238. Price, $15.00. New York, Philosophical Library Inc., 1958.

A prominent feature of medical practice in the past decade has been the tremendous inflow of electrical apparatus and devices into hospitals, clinics and doctors' offices. This development has placed upon the medical staff who operate this equipment and on the technicians who carry out the routine maintenance the need to have a clear understanding of the principles involved, some knowledge of the construction of the apparatus and, most important, full information on the special care required to eliminate possible danger to patients and staff. This book, of British authorship with 21 contributors, aims, therefore, to cater to these needs by providing authoritative information on the principles, operation, care, and routine maintenance of medical electrical apparatus and devices in clear terms which do not presuppose a deep knowledge of electricity. Following an introductory section on the use of electricity in hospitals, and the safeguards necessary, are sections covering particular equipments, including Shadowless Light Fittings for the Operating Theatre, Emergency Lighting Systems, X-ray Apparatus, Radioisotope Diagnotic Instruments, Surgical Diathermy, Instruments used in Physical Medicine, Endoscopes, Electrocardiographs, Electroencephalograph, Respiratory and Suction Apparatus, Dental Engines and Foot Switches, Bone and Plaster Saws, Incubators and Sterilizers. Finally, there is an informative section covering the principles of the various types of small electric motors used in medical equipment.

Negroes and Medicine. By Dietrich C. Reitzes. Pp. 400. Price, $7.00. Cambridge, Mass., Harvard University Press, 1958.

This book provides information on opportunities for Negroes in medicine, and the status of medical care for and by Negroes. It is published for The Commonwealth Fund by the Harvard University Press. The author, who teaches sociology at Indiana University, was director of the project "Negroes in Medicine," financed by the Rockefeller Foundation and conducted under the auspices of the Department of Sociology at the University of Chicago. The first part of the book consists of a description and analysis of Negro applicants to medical schools and of



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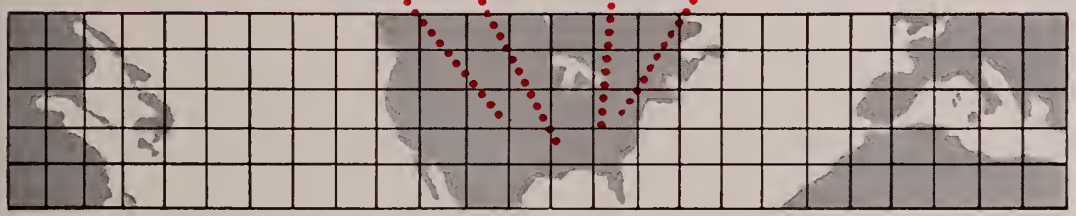
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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6.Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Negro medical students. Data were obtained from the Association of American Medical Colleges, Registrars of Howard University School of Medicine and Meharry Medical College, and a mail survey of 82 other approved medical schools in the United States. The second part presents and interprets the results of a study of 14 communities—Philadelphia, New York, Boston, Chicago, Gary, Detroit, Indianapolis, Los Angeles, Washington, D. C., St. Louis, Kansas City, Mo., Atlanta, New Orleans and Nashville—selected on a continuum ranging from "no integration" to "high integration." The way in which this material is presented and analyzed makes this book a valuable addition to the study of race relations in general as well as in the particular field of medicine.

How to live with Diabetes. By Henry Dolger, M.D., and Bernard Seeman. Pp. 192. Price, $3.50. New York, W. W. Norton & Company, Inc., 1958.

This book will help the person with diabetes live with his condition on the best possible terms, by providing him, his family, and his friends with a full understanding of the disease, the medical principles underlying its management, and the problems imposed and how they are met. Its major emphasis is on the person with diabetes rather than on the ailment itself. While it covers questions of diagnosis and treatment, it is primarily concerned with the human factors, the problems of daily living as they relate to growing up, work, marriage, sex, aging, and the means of adjusting to the numerous physical and emotional demands of the disease. The theories, attitudes, and controversies that have developed around the disease and the practical step-by-step procedures for its control are discussed. Attention is concentrated on those phases of the disease which the patient can help control. For example, chapters are devoted to the meaning of insulin and to the tools and technics of control with insulin; and for the first time in a nontechnical book the new oral drug Orinase, which frees the majority of diabetic patients from insulin injection, is fully discussed.

Leptospirosis in Man and Animals. By J. M. Alston, M.D., F.R.C.P. Edin., and J. C. Broom, O.B.E., M.D. Pp. 367. Price, $8.50. Edinburgh and London, E. & S. Livingstone Ltd., 1958. (The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.)

The aim in this book is to tell what is known about leptospires and the diseases which they cause in man and animals, and to show where new knowledge is at present being gained and may be hoped for in the future. Recently, in the United States, in Malaya, in Israel and in parts of Europe, leptospirosis has been observed with increasing frequency, often caused by serotypes not previously known to be present in those regions. It is a matter of concern that, though in human beings the majority of cases are of the milder forms, the disease may cause an illness which affects people singly or in groups, and may require several weeks of convalescence. During recent years it has been recognized that endemic leptospirosis among farm animals may cause serious financial losses in some countries. The authors, who, by their personal researches, have added materially to the knowledge of leptospirosis, have written this book in historical sequence and have given full references for their statements. They have included epidemiology, clinical and pathologic descriptions of the disease, therapeutics and prevention of infection.

What We Do Know About Heart Attacks. By John W. Gofman, M.D. Pp. 180. Price, $3.50. New York, G. P. Putnam's Sons, 1958.

This book provides a simple, straightforward account of the present knowledge of heart attacks and explains the progress that has been made toward the solution of the problems of heart disease. During the last decade, the knowledge of heart attacks and their origin has accumulated so rapidly as to dispel the myth that such attacks are one of the "inevitable consequences of growing old." The story of this advance is a fascinating one that is understandable by anyone, if stripped of medical verbiage and pretense. There is a tremendous need for an intelligible explanation of the new developments and their meaning for the ultimate eradication of premature heart attacks. Many persons fail to carry through with a heart attack prevention program because they do not know what it is that their physician is trying to do for them. This book will be of great assistance to the busy physician in explaining the whole background of whys and wherefores to the individual patient, and in this one way alone can help to reduce the incidence of heart attacks through improved patient cooperation in the physician's prevention program. The author is Professor of Medical Physics at the University of California.

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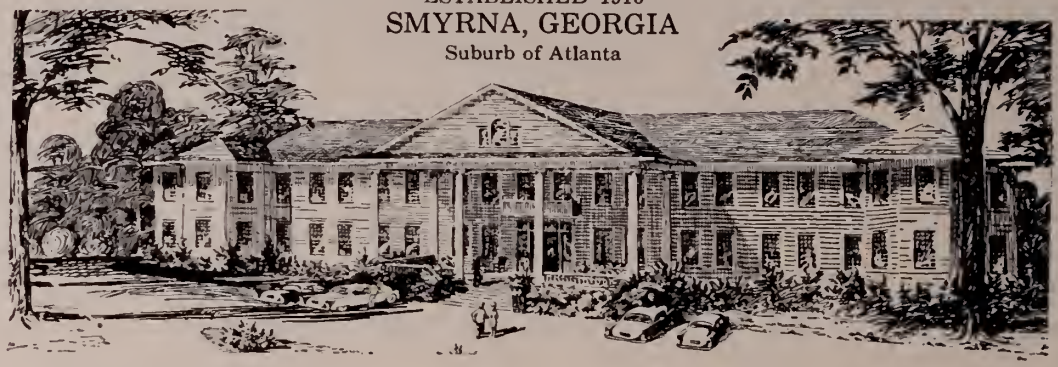
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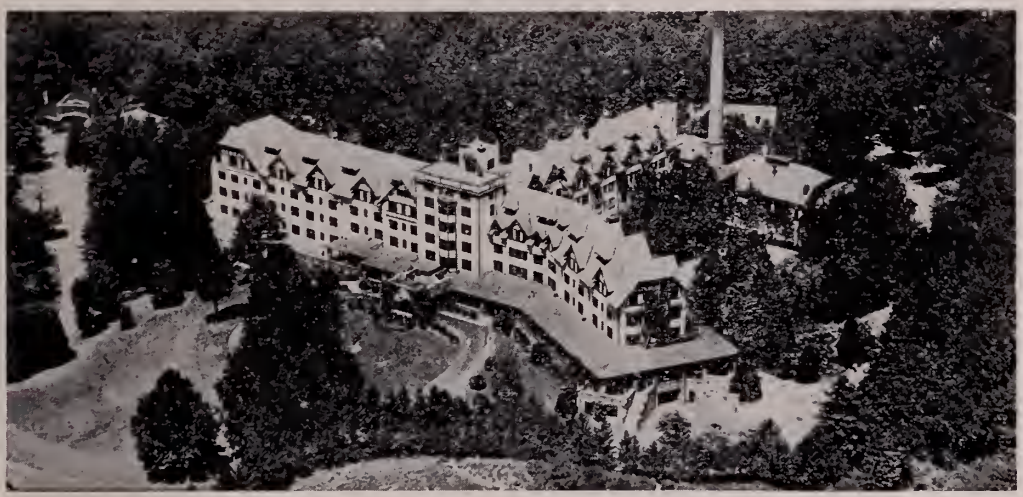
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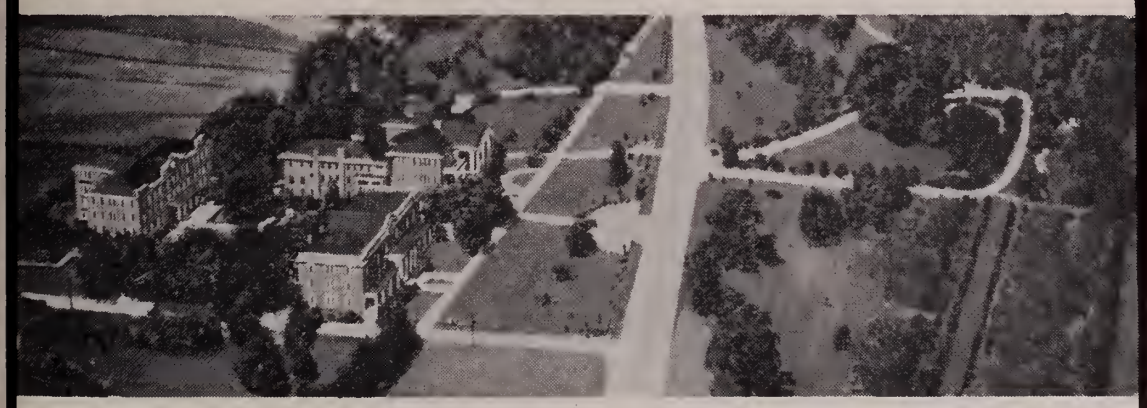
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HOMER L. PEARSON JR., M.D., 1934 *Miami*
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ORION O. FEASTER, M.D., 1936 *Maple Valley, Wash.*
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WALTER C. JONES, M.D., 1941, Chm. *Miami*
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HERBERT E. WHITE, M.D., 1950 *St. Augustine*
DAVID R. MURPHEY JR., M.D., 1951 *Tampa*
ROBERT B. McIVER, M.D., 1952 *Jacksonville*
FREDERICK K. HERPEL, M.D., 1953 *W. Palm Beach*
DUNCAN T. McEWAN, M.D., 1954 *Orlando*
JOHN D. MILTON, M.D., 1955 *Miami*
FRANCIS H. LANGLEY, M.D., 1956 *St. Petersburg*
WILLIAM C. ROBERTS, M.D., Secy., 1957 *Panama City*

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL
Alachua	George H. Putnam, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	62
* *Bradford, Gilchrist, Union*				
Bay	James D. Nixon, Panama City		2nd Tues.	31
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	59
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	223
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	920
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	355
* *Clay*				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	115
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	234
Indian River	B. Bowman Guerin, Vero Beach		2nd Tues.	11
Jackson-Calhoun	Glenn E. Padgett, Marianna	Frances M. Watson, Marianna	Quarterly	15
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	29
* *Sumter*				
Lee-Charlotte-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	Quarterly	75
Madison			Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	33
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	36
* *Levy*				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	8
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	232
* *Osceola*				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	178
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	291
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	125
Putnam	Charles E. Barrineau, Palatka		2nd Tues.	11
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	28
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	82
Seminole	Vann Parker, Sanford		2nd Tues.	16
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	7
* *Dixie*				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	90
* *Flagler*				
Walton-Okaloosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	29
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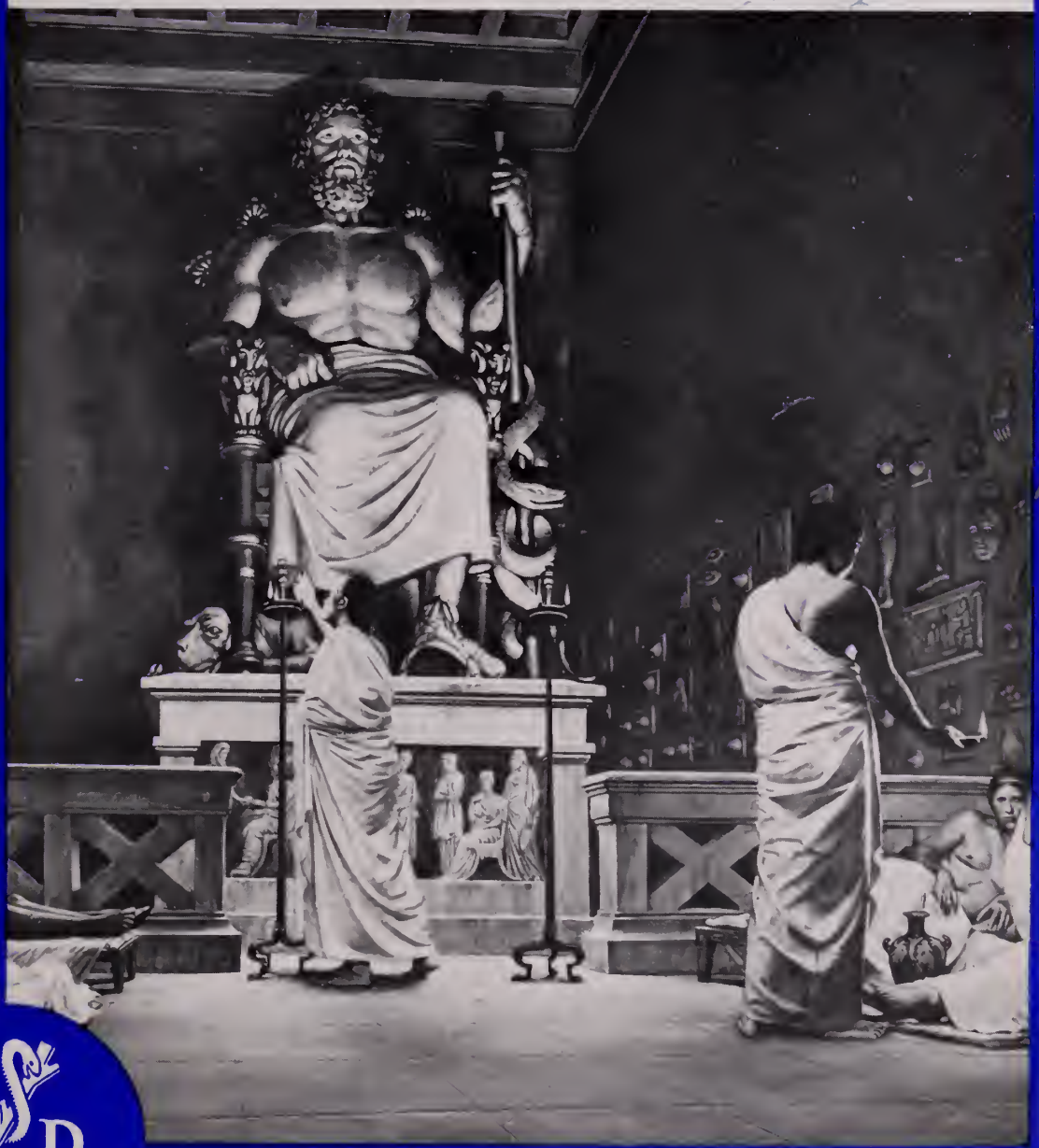
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Vol. XLV MARCH, 1959 No. 9



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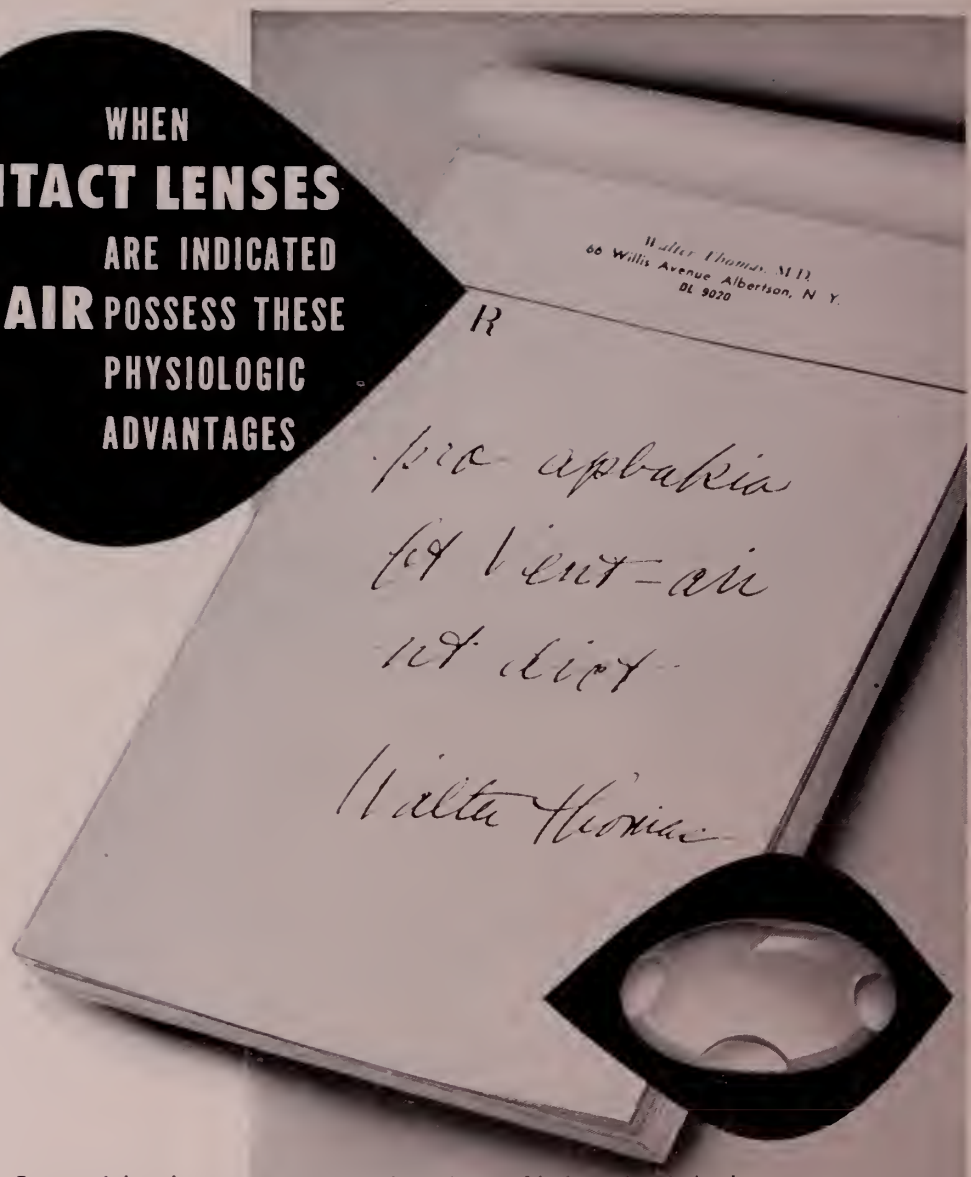
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Four peripheral vents	Permit topical circulation of lachrymal and glandular secretians without excessive motility
Corneal apical clearance	Favars narmal carneal metabolism and oxygenation
Ultra-Smoothness of Inner and Outer Surfaces	Avaid limbal epithelial and torsal conjunctivol exacerbation
Highly absorptive methyl-methacrylate composition	Simulotes "wetting" and moisture-retention properties af corneo (of military specificotian)
Precision-ground	Prescriptive quolities exact to ± 0.12 D. with precise ollowance for vertex refraction and lochrymol foctor (exoct to .02 mm radius in inner curvoture)
Custom-fitted	In uni-, bi-, ar tri-curve rodii conforming to corneol peripherol asphericities
Hyper-thinness of edge or center	Maintains unifarm thickness in high myopia or hyperopia oppraximating .20 mm irrespective of power
Widest range of inner radii	Fram 5.0 to 10.00 mm praviding for extremes of keratocanic ond megaloglobic dimensions
Cosmetic, pin-hole and tinted effects	For leucomotous, polyopic, iridadialytic ond olbinic conditians or other corneol or media anomolies.

VENT-AIR CONTACT LENS LABORATORIES • NEW YORK, N Y

More effective clinically

in LOW BACK PAIN

TORTICOLLIS

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ANXIETY STATES

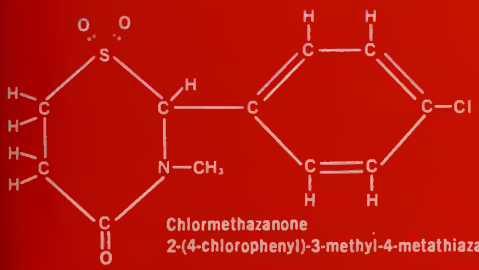
Trancopal®

the first true tranquilaxant

Potent MUSCLE RELAXANT

and equally effective

as a TRANQUILIZER



Chlormethazanone

2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other therapeutic agent in current use. Better tolerated and safer than older drugs.

for clinical results in 4092 patients *see inside*

Trancopal

the first true
*TRANQUILAXANT**

***Potent* MUSCLE RELAXANT**
***and equally effective as a* TRANQUILIZER**

clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant)
[< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

Clinical Comments

"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

Baker, University of Minnesota Medical School

"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm*, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

Lichtman, New York Polyclinic Medical School and Hospital

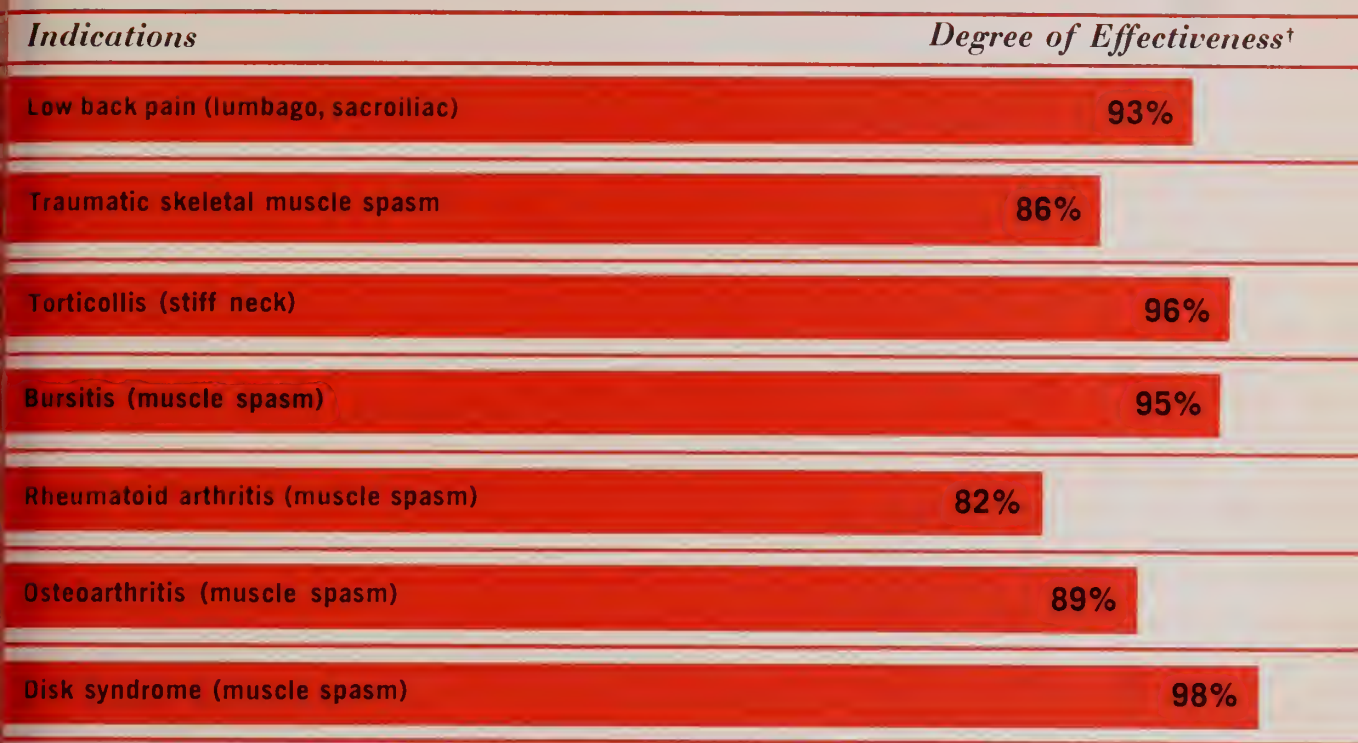
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

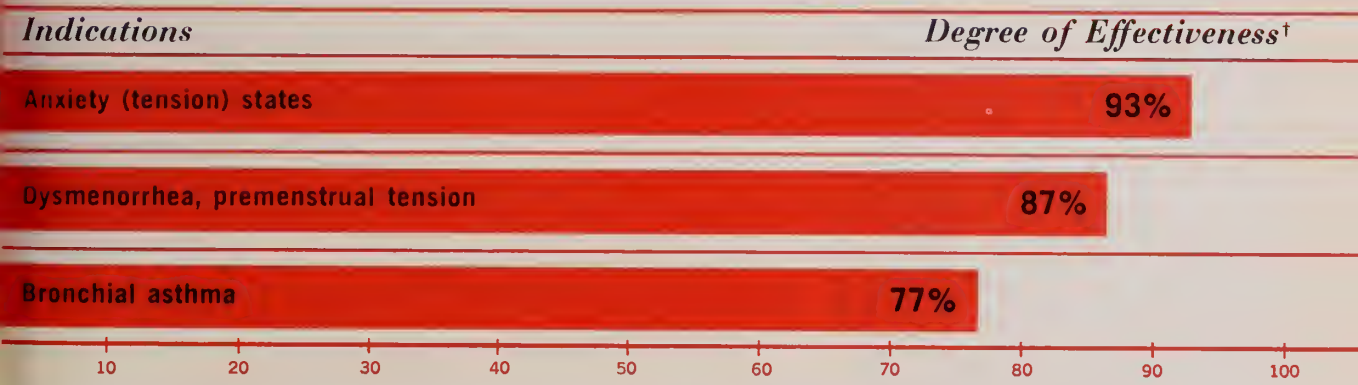
"In 120 patients with *anxiety or tension states*, 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

Lichtman

91% Effective in Musculoskeletal Disorders



89% Effective in Psychogenic Disorders



†*Excellent, good and fair*

The results of clinical studies of over 4092 patients by 105 physicians demonstrate that Trancopal often is effective when other drugs have failed. From these studies it is clear that Trancopal probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other pharmaceutical agent in current use.

Dosage:
Usual adult dose, 1 Caplet (100 mg.) three or four times daily. Children (from 5 to 12 years), ½ Caplet (50 mg.) three or four times daily.

Supplied:
Trancopal Caplets® (peach colored, scored) 100 mg., bottles of 100 and 1000.



Winthrop

Trancopal

the first true tranquilaxant

Potent MUSCLE RELAXANT
and equally effective
as a TRANQUILIZER

ADVANTAGES OF TRANCOPAL

- Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.
- No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- Low toxicity.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.
- No perceptible soporific effect, even in high dosage.

INDICATIONS

Musculoskeletal

Low back pain (lumbago)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
Joint disorders (ankle sprain, tennis elbow, etc.)
Myositis
Postoperative myalgias

Psychogenic

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

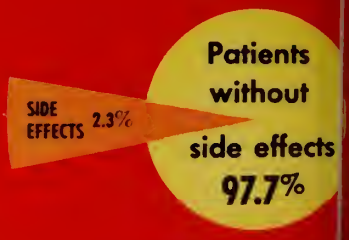
Neurologic

Muscle spasm (in paralysis agitans, multiple sclerosis, hemiplegia, cerebral palsy)

SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice: usual human dose.



INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4262 PATIENTS

SUPPLIED

Trancopal Caplets (peach colored, scored) 100 mg., bottles of 100 and 1000.

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new 3-way build-up for the under par child...

Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate.

new

INCREMIN®
Lysine-Vitamins

WITH IRON SYRUP

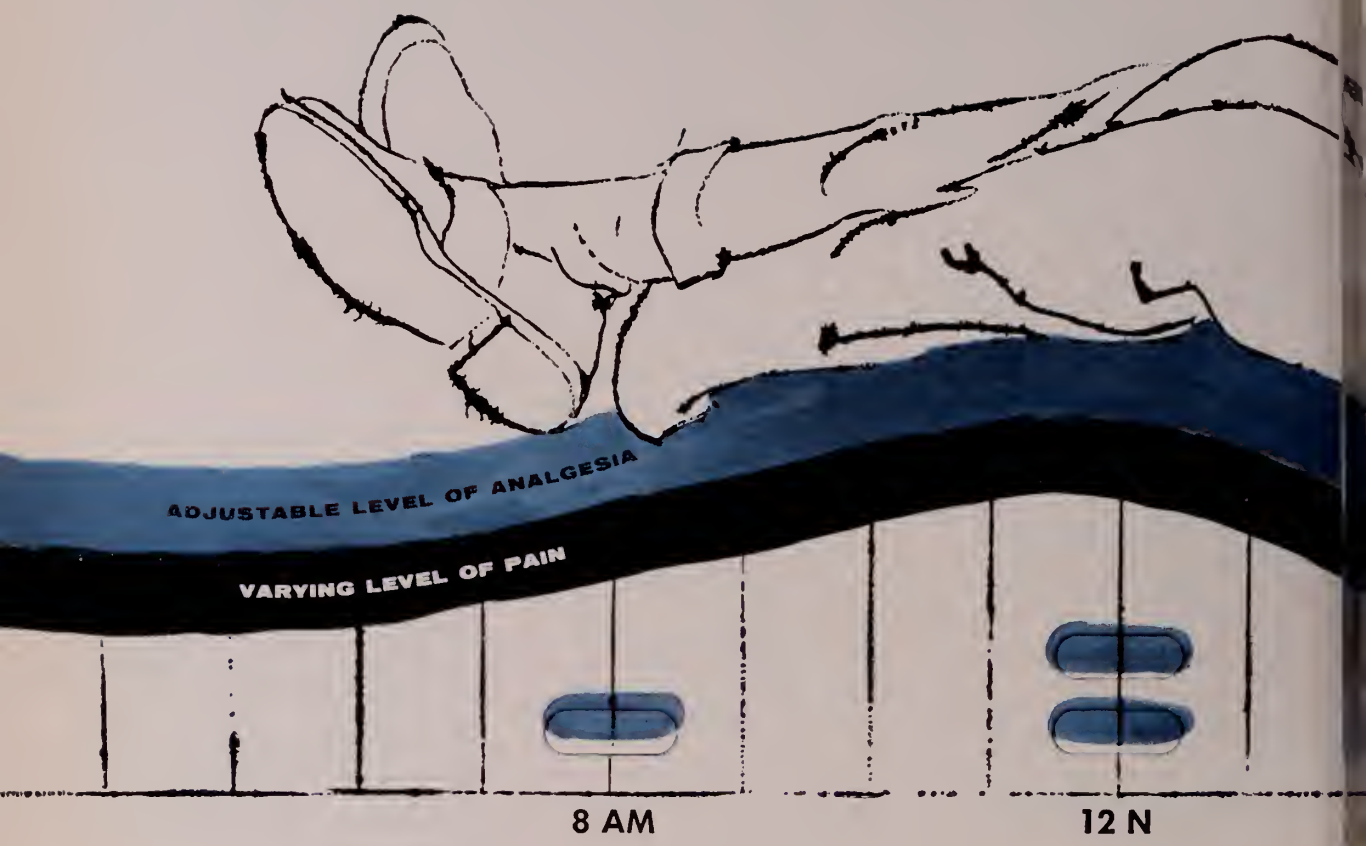
delicious cherry flavor— no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle



keep all patients* pain-free at all times

- with the proper potency to match pain intensity
- with dosage flexibility to match pain variations

Phenaphen®

Robins

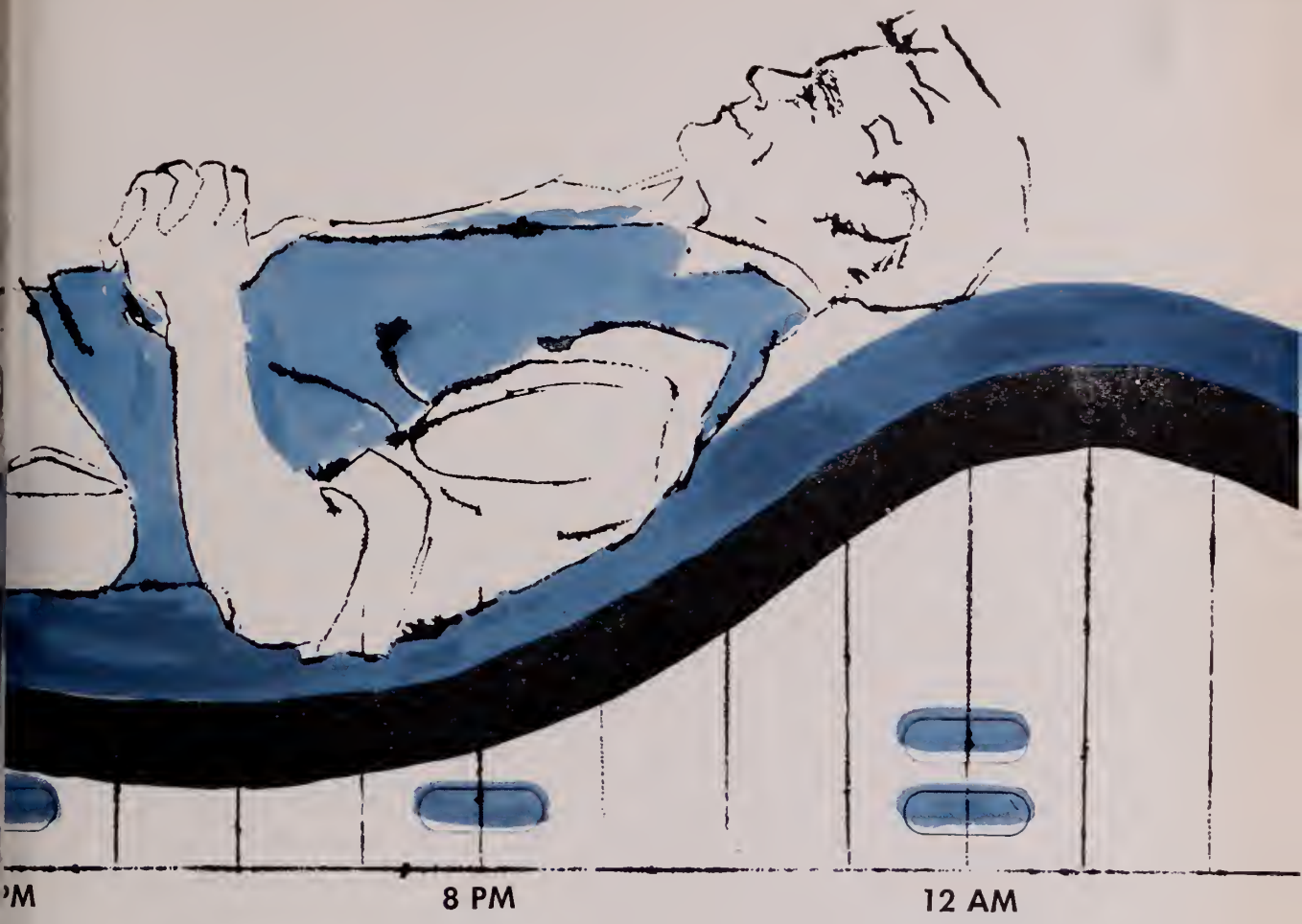
or

Phenaphen® with Codeine

*except those for whom recourse to morphine is inescapable.

Robins A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878



Phenaphen and Phenaphen with Codeine provide
a wide range of analgesia, plus complete dosage flexibility,
to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Phenacetin (3 gr.) .....194.0 mg.
Acetylsalicylic acid (2½ gr.).....162.0 mg.
Phenobarbital (¼ gr.) ..... 16.2 mg.
Hyoscyamine sulfate.....0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

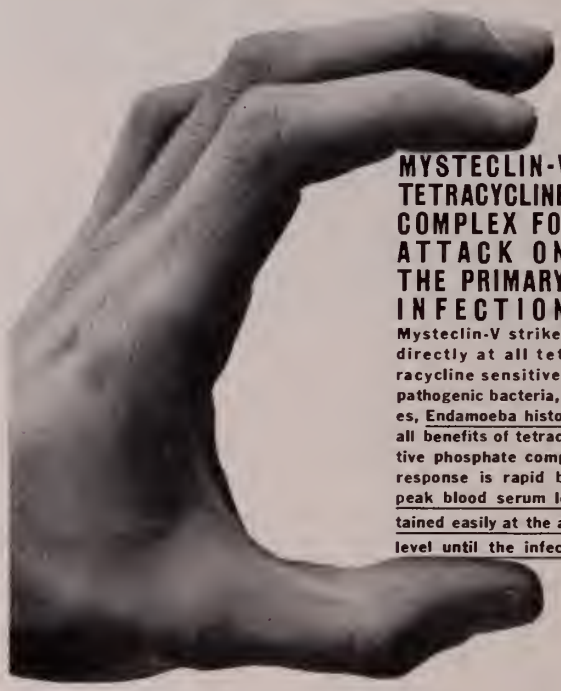
Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

more than tetracycline alone



MYSTECLIN-V CONTAINS TETRACYCLINE PHOSPHATE COMPLEX FOR A DIRECT ATTACK ON THE PRIMARY INFECTION

Mysteclin-V strikes directly at all tetracycline sensitive organisms—most pathogenic bacteria, certain large viruses, Endamoeba histolytica. It provides all benefits of tetracycline in the effective phosphate complex form.[1] Patient response is rapid because initial high peak blood serum levels may be maintained easily at the antibacterial attack level until the infection is conquered.

MYSTECLIN-V CONTAINS MYCOSTATIN FOR A SPECIFIC DEFENSE AGAINST SECONDARY MONILIAL SUPERINFECTION

Mysteclin-V protects patients against antibiotic induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis. This protection is provided by Mycostatin, the antifungal antibiotic, with specific action against Candida (Monilia) albicans.[2]

BOTH ARE OFTEN NEEDED WHEN BACTERIAL INFECTION OCCURS

MYSTECLIN-V

SQUIBB TETRACYCLINE PHOSPHATE COMPLEX (SUMYCIN) AND NYSTATIN (MYCOSTATIN)

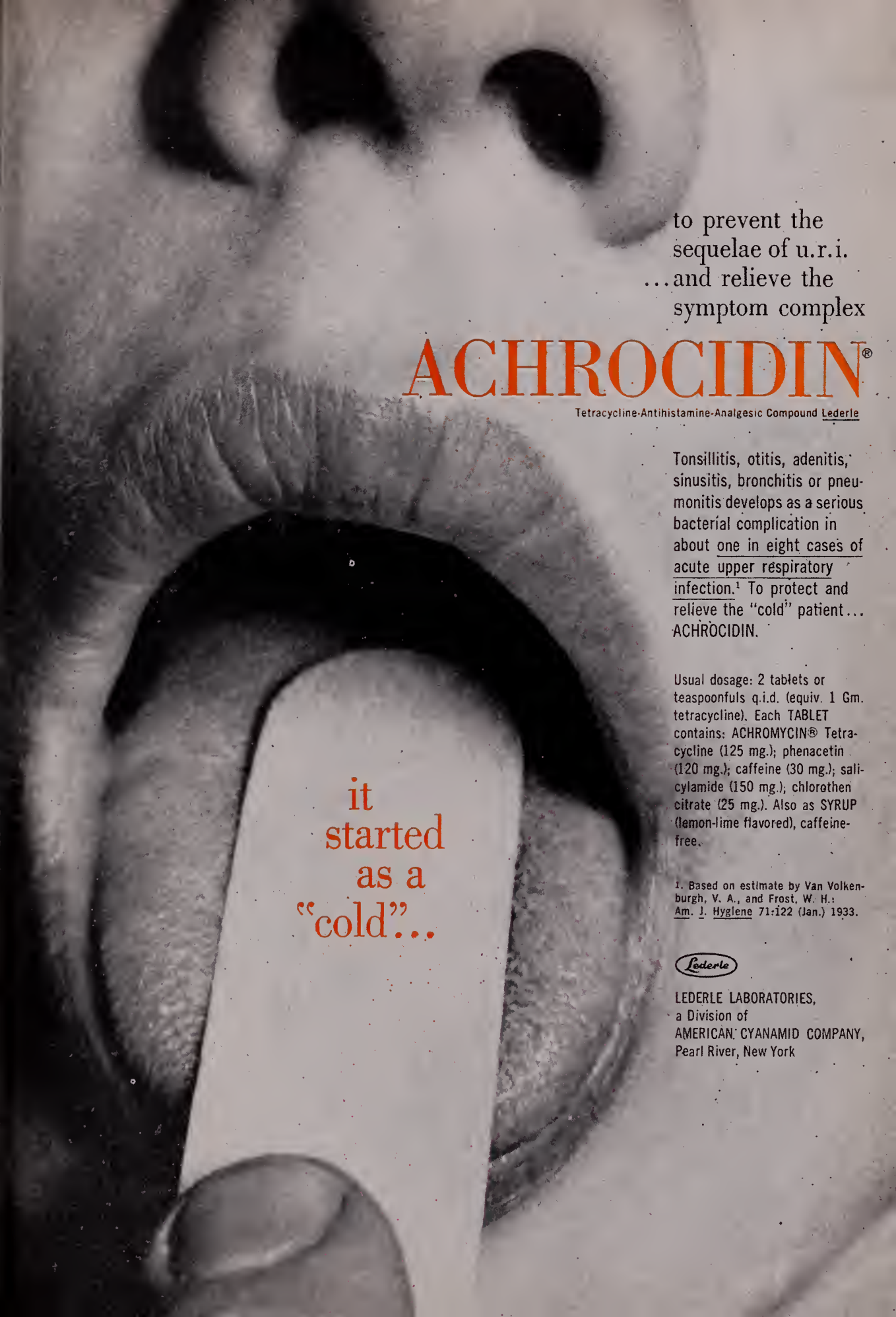
Capsules (250 mg./250,000 u), bottles of 16 and 100.
Half-strength Capsules (125 mg./125,000 u), bottles of 16 and 100.
Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Crunk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958. p. 397. 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955. p. 686.

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Squibb Quality—the Priceless Ingredient

*MYSTECLIN®, *SUMYCIN®, AND *MYCOSTATIN® ARE SQUIBB TRADEMARKS



to prevent the sequelae of u.r.i. ...and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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BONADOXIN®

(tablets and drops)

STOPS STOPS STOPS MORNING SICKNESS



BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride .. 8.33 mg.
Pyridoxine hydrochloride ...16.67 mg.

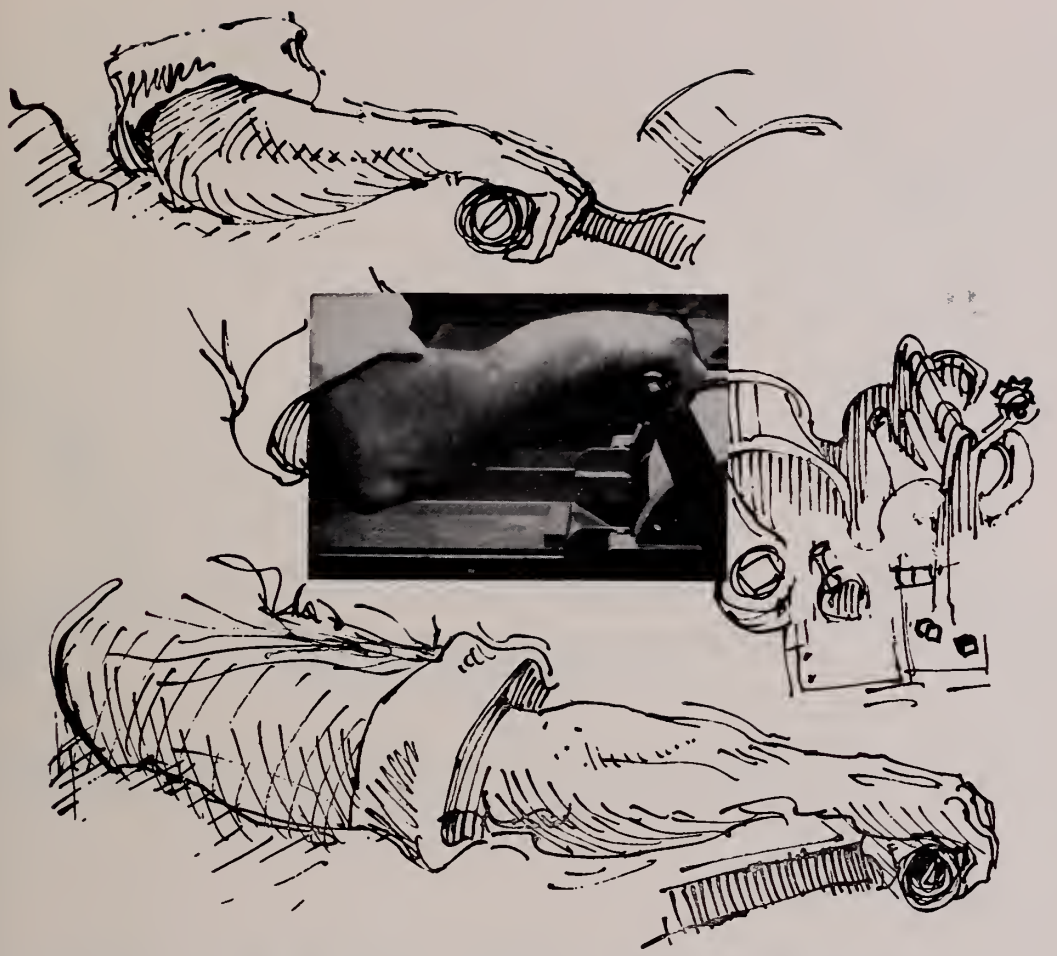
Dosage:

under 6 months	0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years	1.5 to 2 cc.	
2 to 6 years . .	3 cc.	
adults and children over 6	1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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Science for the World's Well-Being



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause.* New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn



Feeling better is part of getting better

Hasamal

to relieve the discomforts of upper respiratory infections

- **relieve pain and tensions**
- **reduce fever**
- **stop excessive nasal secretions**
- **without unwanted diaphoresis***

(especially important for ambulant patients)

*original Haskell formulation

Each HASAMAL tablet contains:

Phenobarbital	16.2 mg. (¼ gr.)
Acetylsalicylic Acid	162.5 mg. (2½ gr.)
Acetophenetidin	162.5 mg. (2½ gr.)
Hyoscyamus Alkaloids	0.0337 mg.

(Equiv. to ¼ gr. Ext. Hyoscyamus)

Dose: One or 2 tablets, repeated as necessary.

The **HASKELL** family of graduated analgesics . . . select the analgesic according to the degree of pain:

HASAMAL—Formula above

HASACODE—Hasamal formula with ¼ gr. Codeine Phosphate

HASACODE "STRONG"—Hasamal formula with ½ gr. Codeine Phosphate

CHARLES C. HASKELL *& COMPANY, Richmond, Virginia*

enables your patient to escape

peptic ulcer symptoms

PRANTAL

Relief from gastric hypermotility and hypersecretion by PRANTAL aids physiological healing of the ulcer. With his freedom from pain and other distressing ulcer symptoms, your patient feels secure in his personal relationships, relatively certain of freedom from exacerbations.

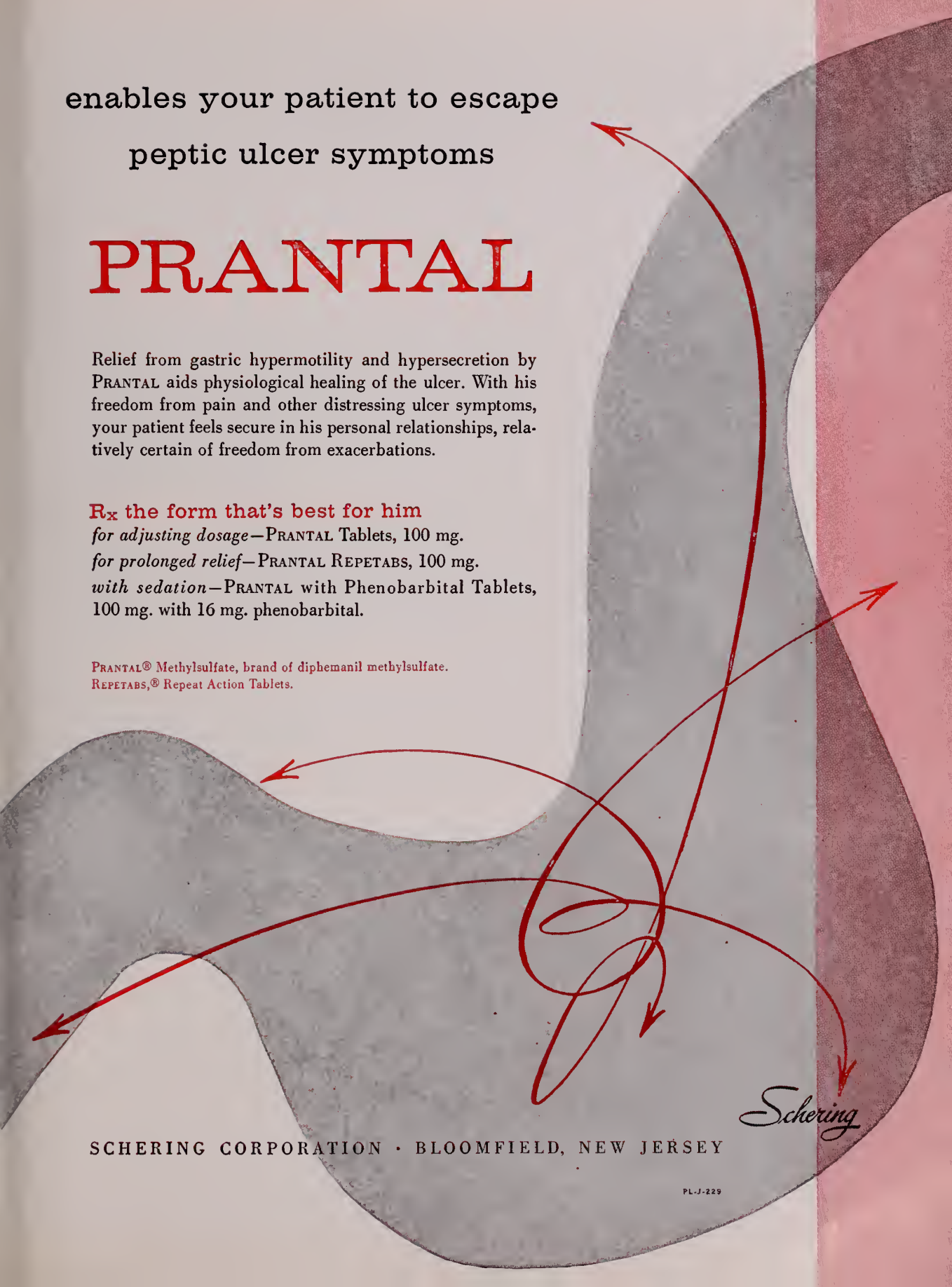
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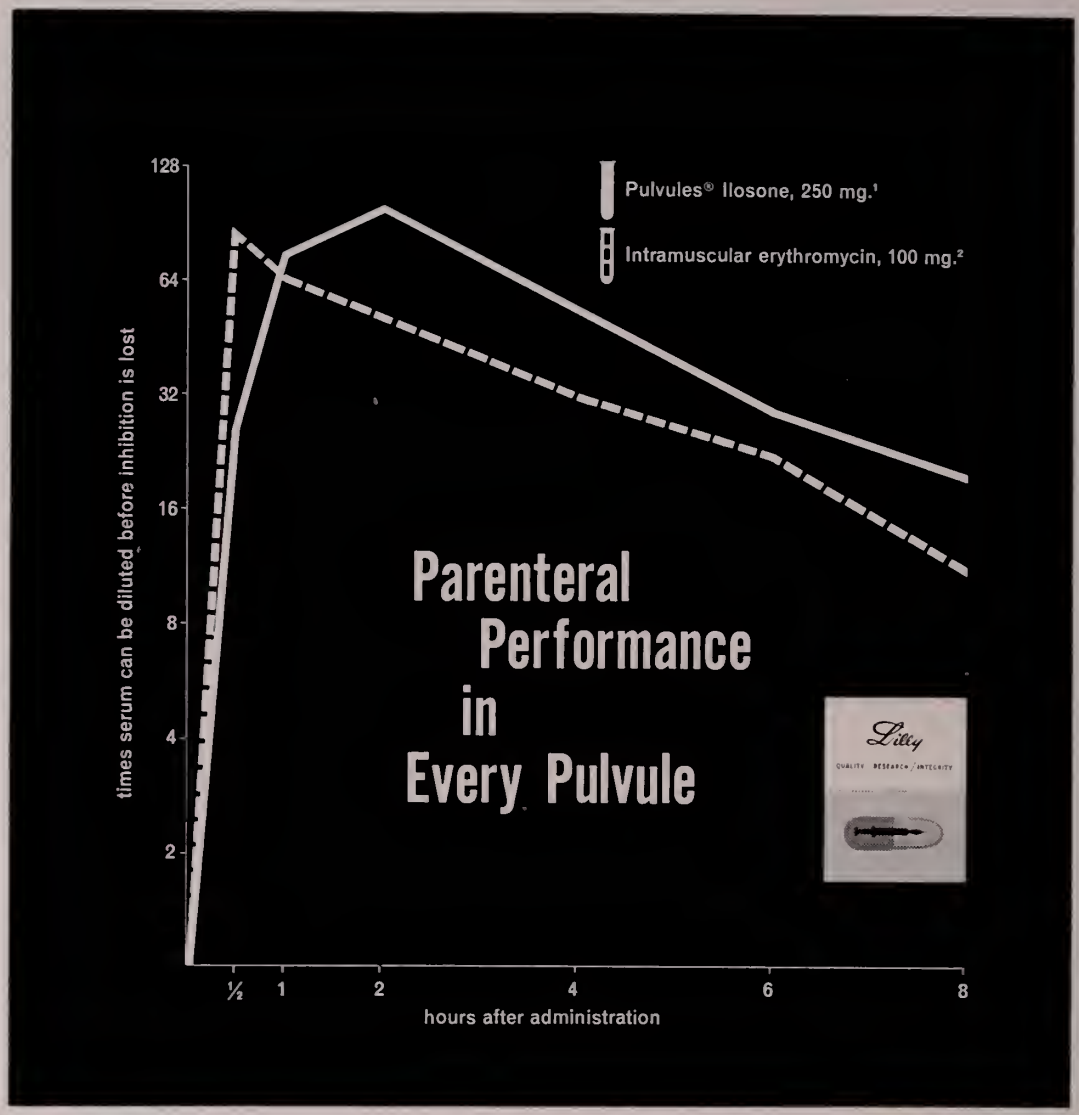
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1. Antibiotic Med. & Clin. Therapy, *5*:609, 1958.

2. Data from Antibiotics Annual, p. 269. 1954-1955.

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Needle Biopsy — A Practical Diagnostic Tool Bone Marrow Examination

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Although many sites are now approachable by the aspirating needle, probably no area has been as frequently or as profitably examined as has the bone marrow. The marrow examination, however, remains a relatively unutilized procedure in many clinical states. Due to its simplicity and unusually high yield of helpful information, this examination should be made more or less routinely in a variety of situations.

When its use as a diagnostic tool was first described by Arinkin[1] about 30 years ago, marrow aspiration was thought to be valuable only in disease processes primarily involving the myeloid elements. These processes encompassed many of the leukemias and some of the anemias of uncertain origin. As experience was gained, however, and histochemical technics were improved, it became apparent that diseases secondarily involving the marrow could also be evaluated profitably by examination of aspirated material.

In table 1 are listed the sites which are routinely used for marrow examination. Actually, any bone containing red marrow (sternum, calvarium, rib, ischium, ilium, scapula, proximal end of the humerus and femur, vertebral body, et cetera) should contain relatively comparable samples of marrow. Marrow morphology will vary somewhat from site to site. Some observers have reported higher yields of positive information from the manubrium than from the body of the sternum. Practically, several considerations generally govern the choice of a site for aspiration: (1) accessibility of the site, (2) presence of tenderness, tumor or roentgen evidence of disease in any of the bones which are candidates for examination, and (3) familiarity with technical aspects of aspiration in any given area. Noted in table 1 is a category entitled "Special." Frequently the special site will be the same as the routine. In many instances, however, marrow aspiration will be indicated in areas which are not generally selected for routine sampling. Probably the most frequent example of this eventuality exists in the instance of a lesion of a vertebral body. Marrow is plentiful at this site, but it is not often used in routine sampling because of inaccessibility. The vertebral body, however, is a common location of pathologic processes which are frequently diagnostically difficult. The lower thoracic and the lumbar vertebral bodies are readily approached by the aspirating needle with the aid of roentgen localization in positioning. In other instances, bone lesions may occur in areas which do not normally contain marrow in adult life. Generally, these lesions can be aspirated satisfactorily if reasonably accessible. A clue concerning their nature can often be obtained by realizing that secondary malignant processes in the bone usually involve areas where red marrow exists.

An example of the method used in aspirating material from bone lesions can be seen in figure 1. The top of the Osgood needle is penetrating the area of disease, and its position is substantiated roentgenographically. Examination of the aspirate readily clarified the etiologic process in this case, and the entire procedure was completed within 20 minutes.

Noted in table 2 are the absolute indications for bone marrow examination. Generally speaking, such an examination is indicated whenever one anticipates the presence of a pathologic process in the marrow.

In table 3, the relative indications for marrow examination are noted. This list could undoubtedly be lengthened, but the major indications are included. One might question the advisability of listing chronic lymphatic leukemia in this category. This entity has been included here, not so much from the standpoint of diagnosis, but be-

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Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

Table 1. — Sites for Bone Marrow Aspiration

Routine:	Sternum, iliac crest, posterior iliac spine.
Special:	Areas of tenderness or of roentgen abnormality in: skull, clavicle, rib, pelvis, vertebral body, proximal humerus, and femur.

Table 2. — Bone Marrow Examination, Always Necessary

Cytopenia:	Thrombocytopenia, leukopenia, anemia of uncertain origin.
Abnormal Cells in Peripheral Blood:	Immature red blood cells, granulocytes, lymphocytes.
Skeletal	Demineralization, Osteolytic or Osteoplastic lesions: generalized or localized.

Table 3. — Bone Marrow Examination, Often Helpful

Systemic Symptoms of Unexplained Origin:	Fever, weight loss.
Possible Marrow Invasion:	Lymphatic leukemia, tumor, lymphoma, xanthoma.
Abnormal Proteins in Serum and or Urine.	
Planning Therapy in Malignant Disease:	Carcinoma prostate, breast, lung. Neuroblastoma.



Figure 1.

cause of the information it affords regarding prognosis and the need for therapy.

Report of Cases

Several cases will be briefly discussed since each demonstrates a different indication for marrow examination and each reveals how this procedure proved to be of practical assistance in solving the particular problem.

Case 1.—A 38 year old Negro housewife was referred to Duke Hospital on Nov. 14, 1957 with a nine month history of gradually increasing abdominal and low back pain associated with loss in weight. She had been extensively and frequently studied at home. Repeated gastrointestinal surveys and roentgenograms of the lumbar spine failed to explain the complaints. Since no disease process had become evident and her incapacity far exceeded objective evidence of organic disease, a functional basis for her complaints was considered likely. When she was admitted to the hospital, an extensive survey revealed herniation of gastric mucosa into the duodenum, questionable tenderness over the lumbar spine generally, and absence of the left Achilles tendon reflex. The hemoglobin estimation was 9.8 Gm. per hundred cubic centimeters, the hematocrit reading 31 per cent, and the white blood cell count 7,500 per cubic millimeter with 6 per cent myelocytes and 9 per cent metamyelocytes. Alkaline phosphatase was 12.5 Bodansky units, calcium 9.2 mg., and phosphorus 3.2, mg. per hundred cubic centimeters. The temperature ranged between 37.5 and 38.8 C. (99.5 and 101.8 F.). Three attempts were made to aspirate marrow, once each in the sternum, anterior iliac spine and posterior iliac crest. The material obtained was largely peripheral blood, but small clumps of tumor cells could be identified. An open biopsy of the ilium confirmed the original impression. Autopsy revealed carcinomatosis, origin unknown.

This problem remained an enigma because of minimal objective findings. Clues to the correct diagnosis were: unexplained anemia, persistent elevation of temperature, elevated alkaline phosphatase in the absence of obstructive biliary tract disease, and the presence of immature granulocytes in the peripheral blood. In figure 2 is seen one of the peripheral blood myelocytes, an abnormality which should always be considered with the utmost suspicion. This cell was the first concrete evidence of marrow disease. Figure 3 demonstrates typical tumor cell clumps as they were found in the marrow aspirate.

An important note of caution should be sounded concerning inability to obtain good marrow samples from the usual sites. The marrow in acute leukemia and marrow replaced by tumor are notoriously difficult to aspirate. The inability to aspirate little more than peripheral blood may be an ominous sign, and biopsy should always follow several unsuccessful attempts to aspirate or trephine marrow since it is rare that one experiences difficulty in obtaining marrow by aspiration from normal persons. Biopsy of marrow from the



Figure 2.

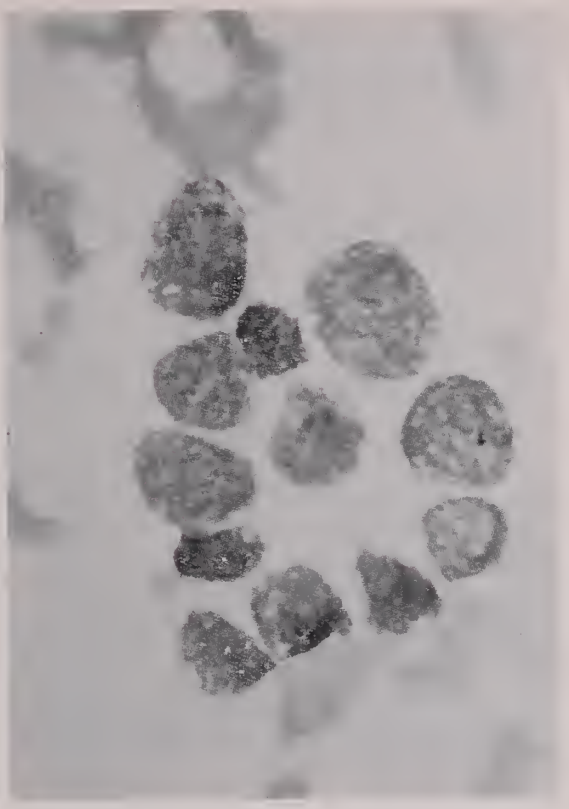


Figure 3.

posterior iliac spine by means of the Vim Silverman needle has been recently described and seems to offer considerable promise, thus obviating the necessity of open biopsy in many cases.

Case 2.—A 54 year old white housewife was first seen by a physician in December 1957, three months after a fall which was followed by gradually increasing low back pain. After roentgen examination of the lumbar spine, a working diagnosis of severe postmenopausal osteoporosis was made. Surgical menopause had occurred 20 years earlier. Braces did not benefit the patient, and her incapacity increased. She was seen at Duke Hospital first in January 1958, at which time the outstanding abnormality was observed in roentgenograms of the lumbar spine. The appearance of the vertebrae was compatible with severe osteoporosis, but further study suggested this diagnosis was not correct. The peripheral blood was entirely normal except for the clue noted in figure 4. Here is seen the autoagglutination which strongly suggested hyperglobulinemia. This suggestion was verified by finding a total serum protein of 10.4 Gm. per hundred cubic centimeters with serum components as noted on the electrophoretic migration pattern pictured in figure 5. The homogeneous band of globulin migrating in the gamma range is pathognomonic, with rare exceptions such as Waldenström's disease, of either plasma cell or lymphocyte neoplasia. The bone marrow with its pronounced plasmacytosis (fig. 6) served only to substantiate the already secure diagnosis of multiple myeloma.

It is of interest to note that two observations, proteinuria and autoagglutination, served greatly to illuminate the nature of this patient's disease process, thus illustrating again the necessity for routinely accomplishing certain basic studies. As

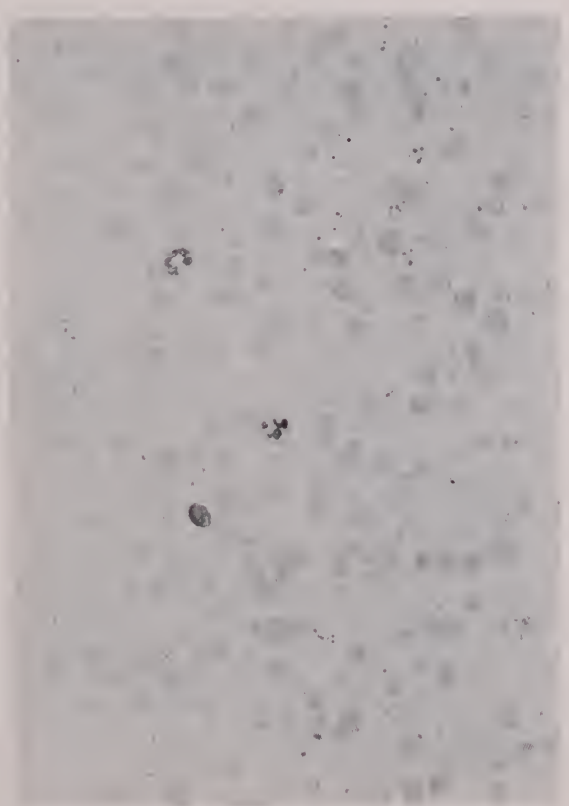


Figure 4.

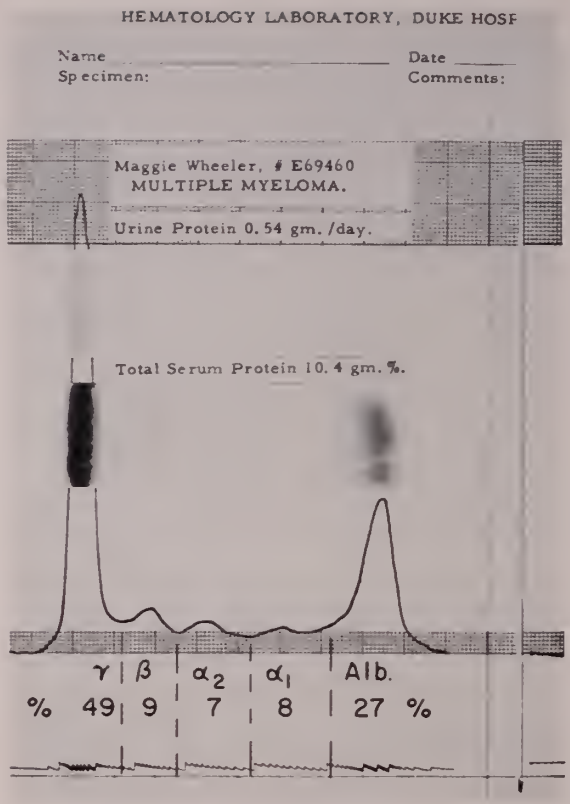


Figure 5.

illustrated by this case, it is probably never wise to diagnose osteoporosis (of more than the expected degree for a given age) without a preliminary bone marrow examination.

Case 3.—A 58 year old white woman had had her illness diagnosed as diabetes mellitus in 1948. She was hospitalized in 1955 for a reactive depression and treated by electric shock therapy. She responded well. Weakness and anorexia began three months prior to admission to Duke Hospital in February 1958 with depression increasing in parallel to the weakness. When she was admitted, the physical examination revealed pale mucosae, a smooth tongue and evidence of dorsal column disease. In addition to a hemoglobin estimation of 6.7 Gm. per hundred cubic centimeters, the white blood cell count was 1,625 and the platelet count 46,000 per cubic millimeter. The gastric contents contained no free hydrochloric acid. Figure 7 reveals a marrow with pronounced megaloblastosis. Vitamin B_{12} injections resulted in a simultaneous increase in hemoglobin, white blood cells and platelets to normal range, with concurrent improvement in cerebration.

Leukopenia and thrombocytopenia not infrequently accompany severe pernicious anemia. This association is not surprising since there is a general metabolic defect at the cellular level. "Megaloblastic" changes can be noted in the cells of the buccal mucosa. Involvement of granulocytes is manifested by giant band neutrophils. "Mega-

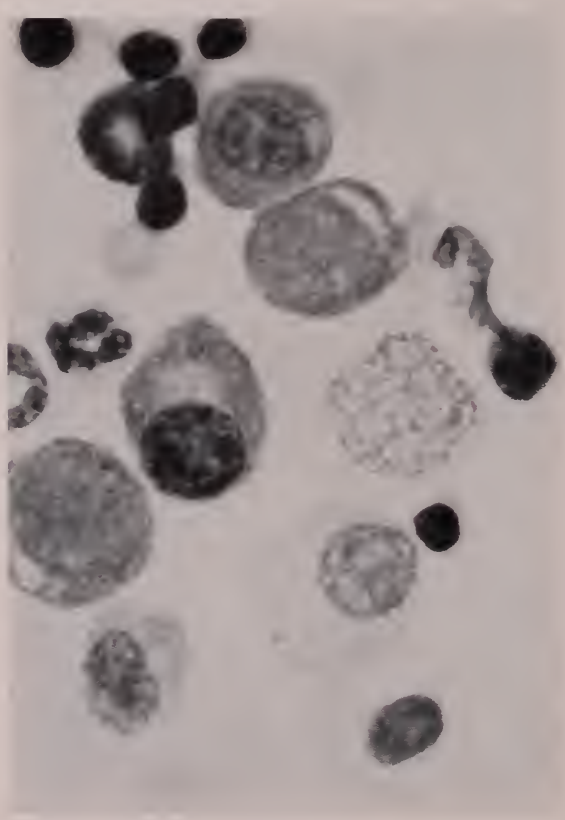


Figure 6.

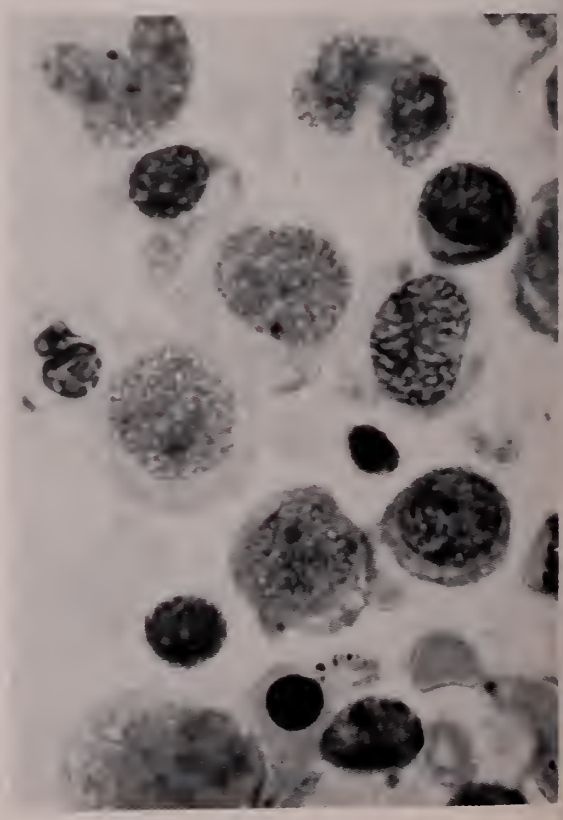


Figure 7.



Figure 8.

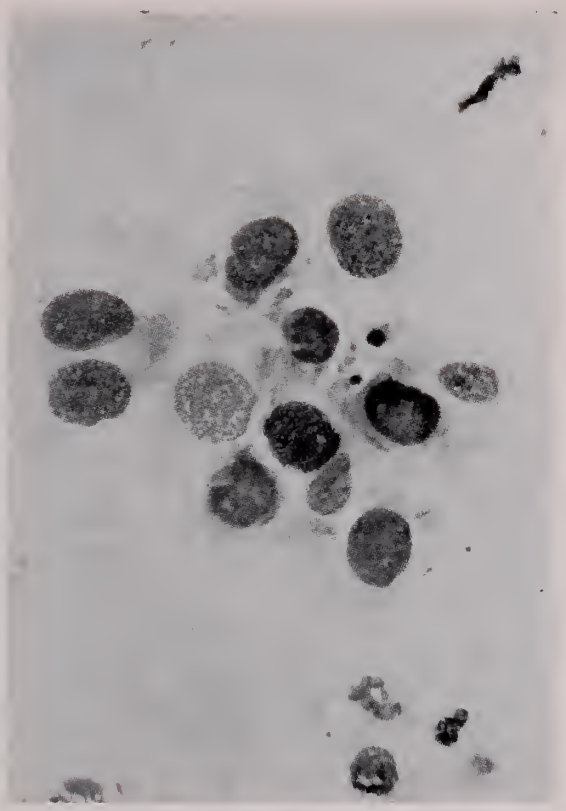


Figure 9.

loblastic" megakaryocytes have been described. Dorsal column disease in pernicious anemia is well recognized, but the frequency with which aberrations of cerebration occur in the same disease is not as often appreciated.

Case 4.—A 33 year old white woman began to notice an aching above the right knee in September 1957. Roentgenograms taken at that time revealed an osteolytic lesion in the lower third of the femur. Biopsy of the lesion elsewhere in January 1958 is reported to have shown reticulum cell hyperplasia. When she was admitted to Duke Hospital in February 1958, the only evidence of disease was an osteolytic femoral lesion. Aspiration of the site revealed cells which were incontrovertibly malignant, and the lower extremity was therefore disarticulated. Final diagnosis made from gross and microscopic appearance was fibrosarcoma. The roentgenographic appearance of the femur is show in figure 8. In figure 9 are seen the aspirated cells.

Aspiration of cells from an area of primary or secondary bone malignancy must qualify for a diagnosis of "malignant cells" by satisfying the criteria of malignancy as set forth by Papanicolaou.[2] Though my associates and I have employed a Romanowsky stain in the process of preparing the aspirates for study in distinction to the fixing and staining processes he described, the same criteria apply. The recognition of tumor cells in marrow is not, in general, difficult, though tumor cells in transudates may pose more of a problem because of the confusing appearance of mesothelial cells and histiocytes in certain instances.

Summary

Bone marrow examination is easily made and is an unusually fruitful area for study not only in primary hematopoietic diseases but also in states in which the marrow is secondarily involved.

It is not implied that aspiration should supplant open biopsy. They should be complementary.

Four cases are presented which demonstrate the practical application of marrow examination in certain states in which the etiology defied identification.

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Trilafon (Perphenazine) and Meticorten (Prednisone) as Ancillary Therapy in Allergic Conditions

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AND
BURTON M. RUDOLPH, M.D.
MIAMI SHORES

A highly labile personality structure is characteristic of the allergic patient. Weiss and English[1] have summarized numerous reports indicating that patients with bronchial asthma, for example, usually have a considerable amount of repressed anxiety and often respond to a conflict situation with an asthmatic attack. The role of psychogenic factors in nasal and dermatologic allergic conditions is less clearly defined. We incline to the theory of multiple causation, which holds that the etiology of these diseases is assignable partly to emotional and partly to physical factors. For this reason, we have usually found it advisable to prescribe a sedative or tranquilizer as well as steroids, antihistamines, and hyposensitization in managing the allergic patient.

One of the newer phenothiazine tranquilizers, Trilafon (perphenazine) appears to be especially useful. Several investigators[2-5] have commented favorably on its salutary effect among patients with allergic and dermatologic disease. The drug appears to act selectively to control anxiety and causes notably few side effects.

The value of Meticorten (prednisone) in bronchial asthma[6-14] and dermatologic allergic diseases[15-19] has been confirmed by extensive clinical experience. This steroid acts much like its older analogue, cortisone; however, Meticorten is about four times as potent as cortisone and does not cause the sodium retention and potassium loss which occur fairly frequently with the latter drug.

We believe that both the steroid and the tranquilizer are of distinct value as symptomatic and ancillary therapy in allergic patients. This report is concerned with a small series of patients who received these drugs concurrently with hyposensitization therapy.*

* Trilafon and Meticorten were made available to us for clinical trial by G. Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation, Bloomfield N. J.

Method

This series consisted of 32 patients with allergic diseases in which a pronounced psychosomatic factor could be presumed. Treatment consisted of multiples of 2 mg. Trilafon and 2.5 mg. Meticorten tablets administered for periods of from one week to four months. Originally the drugs were given separately, but later a combination tablet became available.

BRONCHIAL ASTHMA. — Most patients were victims of bronchial asthma; there were 11 males and nine females, ranging in age from eight to 58 years. Many had intercurrent diseases. There were five patients with eczema, three with hay fever, three with allergic rhinitis, one with conjunctivitis, one with bronchitis, and one with diabetes. All patients received hyposensitization procedures during the trial with chemotherapy. In addition, three patients required antibiotics for concurrent infections, two received courses of erythromycin alternating with the steroid therapy, and one patient was continued on antihistamines which had been effective previously.

The patients in this group had been victims of asthma for some years, and most had been treated previously with antihistaminics, antibiotics, sympathomimetics, other steroids, or local symptomatic therapy. One patient had undergone two operations for nasal sinusitis and one, an emotionally disturbed child, had received inpatient psychiatric care.

Meticorten and Trilafon tablets were administered for short periods of time, usually one week, and then resumed as needed. The starting dosages were 16 or 8 mg. Trilafon and 20 or 10 mg. Meticorten. These were stepped down gradually until only 2 mg. Trilafon and 2.5 mg. Meticorten were given daily.

ALLERGIC RHINITIS.—There were three male and five female patients, ranging in age from 32

to 49 years, with allergic rhinitis. One also had conjunctivitis and another had allergic bronchitis. Hyposensitization therapy was carried out for all patients, and they received, also, 16 or 8 mg. Trilafon and 20 or 10 mg. Meticorten tablets daily for several days during an acute attack. Dosage was then either reduced or discontinued and resumed as needed. Local symptomatic therapy only had been used previously in all but one patient.

Dermatologic Diseases of Allergic Origin.—We also treated two female patients, one aged 30 years and one 53 years, with dermatitis. Both received 16 mg. Trilafon and 20 mg. Meticorten tablets daily for several days; dosage was then halved and continued for four months in one case and two months in the other. Topical therapy was used also for both of these patients before and during treatment with Trilafon and Meticorten orally. A male patient of 41 years with eczema was treated with 8 mg. Trilafon and 10 mg. Meticorten tablets, and later half this dosage, for four months, during which time a restricted diet was followed and hyposensitization procedures were carried out. A female patient with angioedema, 45 years old, received 8 mg. Trilafon and 10 mg. Meticorten tablets for four months, and hyposensitization. Previously, she had received antihistamines, ephedrine, and adrenalin with only moderate effect.

Results

Bronchial Asthma.—Among the 20 patients with bronchial asthma, results were excellent in six, good in 11, and fair in two. Trilafon-Meticorten therapy was discontinued in a girl of nine years who complained of colic and diarrhea after administration.

The combination of these agents provides superior ancillary therapy for asthmatic patients and is useful for symptomatic relief while hyposensitization procedures are carried out. We were especially impressed with the improvement made possible by addition of the tranquilizer to standard therapy; several patients, whose disease had been controlled only moderately well before, showed significantly better results during the new regimen. We believe that relief from tension reduced the frequency and severity of attacks and helped patients cope with remaining symptoms. One patient who had eczema and bronchial asthma, both of allergic origin, noted a great reduction in pruritus when Trilafon was added to his previous treatment with antihistamines, steroids, and hyposensitization.

The improvement in mood was especially evident among older patients. Although drowsiness has been reported as a side effect of Trilafon, we noted almost an opposite effect in patients over 50. They seemed more interested in activity, possibly because the introverting influence of apprehension was modified.

Allergic Rhinitis.—Results in the eight patients with allergic rhinitis were favorable also. Complete relief occurred in one patient, good results were seen in six, and there was one poor result in a patient who responds favorably only to antihistamines. Again, the Trilafon and Meticorten therapy is best used as an adjunct to hyposensitization. Two patients received the drugs separately and also, later, in the combination tablet. Inexplicably, since dosage was the same, one patient had better results when the drugs were administered separately, and one had better results on the combination.

Dermatologic Diseases of Allergic Origin.—The two patients with dermatitis improved considerably; in both instances the Meticorten tablets were more effective than topical steroids, and the tranquilizer seemed to reduce pruritus. This result is especially important since the traumatization which occurs from constant scratching prevents any medication from taking proper effect until this nervous factor is eliminated. The patient with uncomplicated eczema and the patient with angioedema had excellent results with Trilafon, Meticorten, and hyposensitization.

The absence of side effects was notable. All patients were followed carefully through frequent laboratory and clinical evaluations during therapy. There were no disturbances of normal values. The diabetic patient tolerated the steroid perfectly; all symptoms disappeared for the first time in many months, and there was no increase in the urinary or blood sugar. We did not encounter drowsiness or other sequelae associated with perphenazine tranquilizers, and no patient showed any ill effect from Meticorten. We do not believe that the colic and diarrhea which occurred in one child was actually a drug side effect. Since, however, there was at least a possibility that it may have been due to Meticorten, we decided to withdraw therapy.

Undoubtedly the freedom from side effects in this series was due to the low dosages of Trila-

fon and Meticorten which were used. The maximum dose of Trilafon was 16 mg. daily and of Meticorten 20 mg. daily, and these amounts were used only for short periods. The maintenance dose in patients who received these agents continually for several months rarely exceeded 4 mg. of Trilafon and 5 mg. of Meticorten daily. The complementary action of these drugs explains their effectiveness at minimal dosage levels.

The major advantage of the combination tablet is its convenience; it is especially desirable for children. Greater flexibility of dosage is achieved, however, if Meticorten and Trilafon can be administered separately. We have occasionally administered extra 2 mg. Trilafon tablets when a greater tranquilizing effect seemed desirable.

Summary and Conclusions

Thirty-two patients, of all ages, with dermatologic, nasal, and respiratory allergic diseases were treated with Meticorten (prednisone) and Trilafon (perphenazine). The usual starting dosages were 20 or 10 mg. of the steroid and 16 or 8 mg. of the tranquilizer daily; these amounts were reduced, usually over a period of one week, until maintenance doses were determined or therapy was discontinued. Hyposensitization procedures were carried out in all patients.

Good or excellent results were obtained, usually rapidly, in 28, or 87.5 per cent, of the patients. Acute symptoms were relieved, and the emotional stabilization helped reduce the frequency and severity of subsequent attacks.

Clinical or laboratory evidence of untoward sequelae was absent except in the case of one child in whom an attack of diarrhea and colic may have been caused by the steroid. The low dosage, made possible by the complementary action of both agents, undoubtedly prevented side effects.

The combination of Meticorten and Trilafon in allergic patients provides the beneficial effects of an adrenal steroid and significant relief of the emotional tension which is a known exacerbating factor. It acts rapidly and thus is useful for immediate symptomatic relief as well as for ancillary therapy in standard long term management.

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Nonfluorescent Microspora In Tinea Capitis

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It is a popular conception that the presence and extent of microspora infection of scalp hairs can be determined by the use of filtered ultraviolet rays (Wood's light). That this belief is not always true is illustrated by the following report of a case of tinea capitis resulting from a nonfluorescent variety of Microsporum gypseum.

Report of Case

An eight year old girl, seen in the office, complained of an oozing mass on the head of six weeks' duration. No medication had been used other than soap and water. There was no history of exposure to infected animals.

Examination revealed a boggy, inflammatory mass occupying an area about 6 cm. in length on the left parietal region of the scalp. The kerion contained numerous pustules as well as broken, lusterless hairs. There was pronounced tender cervical adenopathy. Numerous hairs, manually epilated from the involved region, were nonfluorescent on examination by Wood's light. KOH-ink mounts of affected hairs, however, revealed mycelia and spores. Several of the nonfluorescent hairs were planted in Sabouraud's agar. Within two weeks, the office-grown culture revealed a dusty, granular, cinnamon-like discoid colony which grew rapidly and developed a central white umbo (fig. 1). Microscopic examination of cultured specimens revealed three to nine septate elliptic thin-walled macroconidia in great numbers in all fields (fig. 2). Repeated examination by Wood's light gave negative results for fluorescence.

Compresses of Burow's solution and pHisoderm shampoo were applied locally. After the lymphadenopathy had subsided, ammoniated mercury ointment was added to the regimen. The lesion healed in about eight weeks following a period of temporary alopecia.

Comments

The incidence of M. gypseum infection of the scalp is very low. In one of the larger series, Lewis and Hopper,[1] in 1948, reported six cases of M. gypseum infection in 456 patients with tinea capitis. In 1950, Sharp and Wegner[2] reported fluorescence in all eight cases seen over a period of 13 years. In contradistinction, Thrice and Shafer,[3] in 1951, reported two cases of M. gypseum which were not of the fluorescent type. Wilson and Plunkett,[4] in 1951, observed seven cases in which fluorescence of this organism was lacking. This group then postulated the existence of possibly two organisms, Microsporum fulvum with an endothrix arrangement without fluorescence and M. gypseum, as described by Bodin, which does fluoresce. Other writers in the mycologic and dermatologic literature stated, in essence, that the infected hairs of M. gypseum have

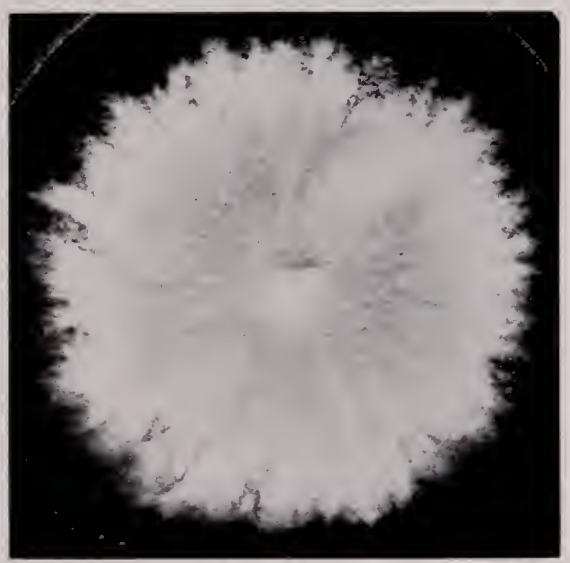


Fig. 1. — Microsporum gypseum colony, two weeks old, in Sabouraud's agar reveals a dusty, granular, cinnamon-like discoid colony with a central white umbo. x10.



Fig. 2. — Microsporum gypseum infection of the scalp. Numerous thin-walled elliptic macroconidia fill the field. x758.

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a greenish fluorescence,[5-8] or they may not be noted in an edematous patch.[1] Frank and Taschdjian[9] summed up the situation by noting that fluorescence may or may not be observed. Pillsbury, Shelley and Kligman[10] and also Behrman[11] indicated that hairs infected with M. gypseum do not fluoresce. Sutton[12] stated that M. gypseum generally produces no fluorescence.

While it is well known that some fungi which invade the hair, such as T. tonsurans, violaceum and schoenleini, do not fluoresce upon examination with Wood's light, the literature is not clear concerning the status of M. gypseum. In view of the case presented and in the light of observations of numerous workers, M. gypseum may appear as strains varying from fluorescent to nonfluorescent organisms. The low incidence of the disease makes it difficult to determine the frequency of nonfluorescence of M. gypseum. All suspicious scalp lesions in children, and in the absence of Wood's light fluorescence, should be studied microscopically and culturally to rule out the presence of nonfluorescent M. gypseum. The clinical appearance of this M. gypseum lesion and the course of the disease paralleled infection of the scalp with Microsporum canis.

Summary

A case of tinea capitis caused by a nonfluorescent variety of M. gypseum is presented. The diagnosis was established by direct microscopic examination and by culture. Negative results of examination by Wood's light do not rule out tinea capitis.

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Surgery in the Aged

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As longevity has gradually increased, the elderly surgical patients have increased in recent years, bringing with them many special problems. In 1900 the average expectation of life span in the United States was 49 years; in 1956, it was 69 years.

Surgical problems among aged patients are often unique, different and difficult. More than in any other group of patients, the entire patient has to be considered. The chief complaint and history may be fragmentary, lacking, or even misleading. More reliance has to be placed on observation and physical findings when treating the aged.

For evaluation of the senile patient for surgery I usually obtain the history, a careful physical examination, and the following basic laboratory aids; chest x-ray, electrocardiogram, complete blood count, urinalysis, urine concentration test, hemoglobin level, blood sugar, and nonprotein nitrogen.

Multiple Diagnoses

In no other group of patients is the problem of multiple diagnoses present as in the aged. It is usually the rule rather than the exception that several important pathologic conditions are coexisting in the same patient. Frequently cardiac failure, uremia, or dehydration is more serious than the surgical condition for which the patient was referred.

The following example illustrates this problem: A man, aged 74, who was sent to surgery for an acute surgical condition of the abdomen, also had the following diagnoses: hypertensive

and arteriosclerotic heart disease with decompensation, arterial hypertension, severe secondary anemia, peripheral vascular arteriosclerotic occlusive disease of the lower extremities, and cerebral arteriosclerosis.

Malnourished and Obese Elderly Patients

Two types of patients that are particularly poor surgical risks are the elderly malnourished and the elderly obese persons. Careful preoperative care can often help these patients through their surgery.

Undernourishment is a frequent problem whenever aged patients are being treated. It frequently is not caused by organic lesions, but is due to organic changes in the brain with reactive disinterest in food, loneliness and fear of a useless future. There may be few or no clinical findings of avitaminosis such as glossitis or peripheral neuritis. Serum studies often show no appreciable decrease in ascorbic acid, nicotinamide, thiamine hydrochloride or riboflavin.

Undernourished senile patients have less glycogen reserve in their livers and muscles, which tends to make them poor operative risks. In such patients, even if clinical signs are absent, avitaminosis can be assumed to exist. They have impaired physical and mental tolerance to trauma. In the preparation of such patients for surgery, parenteral vitamins rather than oral, especially vitamin B factors, and ascorbic acid are most useful.

Even though the blood count and hemoglobin level seem to be within normal limits, secondary anemia comparatively actually exists in severely undernourished patients because the total volume of blood is less than it normally should be. Aged patients rebuild their blood cells in the bone marrow more slowly. Transfusions of whole blood are recommended more freely, especially when time is important.

The aged obese patients are also poor surgical risks. Postoperative vomiting, paralytic ileus, and pulmonary complications are more common in obese patients. Usually, operative procedure is technically more difficult and more time-consuming, placing further strain on the obese patient's heart.

Preoperative Care

The safety for operation, especially in senile patients, depends directly on the excellence of preoperative examination and care. The majority of prepared elderly patients show improved morale, physical tolerance and more self sufficiency.

Shallow respirations and lessened lung capacity gradually develop in aged persons. Also, a low oxygen level favors depression of the cerebrum and vital centers. Deep breathing exercises and ambulation for several days prior to operation are helpful in increasing oxygenation of the blood and lessening complications.

Senile patients react somewhat like children under 10 years of age to certain preoperative sedative drugs as they are more sensitive to vagus stimulation. Morphine is not well tolerated and may cause respiratory depression. Scopolamine should be avoided in elderly patients as it tends to produce temporary confusion. Small doses of Demerol and atropine sulfate are my preference for a preoperative sedative.

Postoperative Care

Postoperative early ambulation in elderly patients reduces complications and speeds convalescence.

During his waking hours, deep breathing, leg and foot exercise should be performed every hour while the patient is in bed. Ambulation increases the activity of respiration, circulation and intestinal function. When he is recumbent, vascular stagnation in the limbs is increased, leading to thrombosis. When he is erect, the rate and depth of respirations are increased, vital capacity is greater, and coughing is easier and helps to dislodge mucus plugs, which cause atelectasis and bronchopneumonia.

Many old people, especially if their memories are impaired, have lost considerable ability to adjust themselves to stresses and changes such as surgery entails. The most frequent reaction to operative trauma and confinement to bed is confusion and disorientation for time, place, and person. Some agitation, destructiveness and incontinence of urine may occur. The senile patient may show enough combativeness literally to exhaust himself to death.

Small doses of the milder tranquilizing drugs postoperatively have been found most useful to prevent and to treat this complication. A friendly relative or attendant and a dimly lighted bedroom throughout the night help to prevent disorientation. Excessive fears should be allayed by repeated reassurance and repeated simple explanations.

Summary

The aged have increased in recent years, and their care has created special surgical problems.

Surgical problems among the aged are unique and often difficult because of multiple pathologic conditions coexisting in the same patient.

Senile patients often react to serious trauma with mental confusion. Careful nursing and the milder tranquilizing drugs are useful in such cases.

Early postoperative ambulation reduces complications and speeds up convalescence.

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Clinical Trial of a New Laxative Combination (Stimulant-Detergent Type)

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The study of laxative medication, a long dormant field of investigation, has recently undergone a vigorous revival. The stimulus was the introduction of a detergent, dioctyl sodium sulfosuccinate (Aerosol O.T., abbreviated DSS) into clinical practice.[1] The most desirable property of this new therapeutic agent is its complete chemical inertness. It lowers surface tension at the interfaces of various types of intestinal contents and thereby increases the penetration of solid by fluid material. As a result, surface-active laxative drugs appear to be the treatment of choice in those types of constipation that are characterized by the presence of desiccated, scybalous stools.

This action is restricted entirely to the intestinal lumen, and DSS exerts no demonstrable action of any kind upon the intestinal mucosa, musculature or autonomic innervation. This inertness is a disadvantage in cases of constipation in which hardness of stools is not the main or a major factor. In such types of constipation, detergents are relatively ineffective. For this reason, Antos[2] suggested that they be combined with laxatives of the stimulant type. Antos employed 1,8-dihydroxyanthraquinone, an effective peristaltic stimulant. He reported that this combination was of value in the majority of his patients, and that DSS served to reduce the amount of stimulant laxative needed in each individual patient.

A comparative study of the laxative effectiveness of a series of intestinal stimulants[3] has shown that the relative potency of diacetyl-dihydroxyphenylisatin (abbreviated DDP), on a comparative scale assigning the value of 1.0 to phenolphthalein, is 20.9, while the potency of 1,8-dihydroxyanthraquinone is only 0.4. DDP was discovered and isolated in 1925 and has since then been reported to be nonabsorbed and nontoxic in spite of its high effectiveness.[4,5] It is possible that this high therapeutic ratio is connected with the fact that DDP is the active ingredient of prune concentrate.[6]

These facts suggest the possibility that a combination of the stimulant DDP and the detergent DSS may serve as a useful synergistic laxative. Combinations of the two basic substances* were therefore subjected to clinical trial.

Analysis of Series

Fifty-seven consecutive general practice patients complaining of constipation were treated with this medication. The average dose was 2.0 to 2.5 mg. of the stimulant, DDP, combined with either 200 (Group I) or 100 (Group II) mg. of the detergent, DSS. As shown in tables 1 and 2,

*Two types of tablets were used, 6 in this study, one containing 100 mg. of DSS plus 1.0 mg. of DDP, the other 100 mg. of DSS plus 2.5 mg. of DDP. The latter tablet is available as Isadoxol® from the G. F. Harvey Company, Sarasota Springs, N. Y.

Table 1. — Results of Treatment of Chronic Constipation With a Laxative Combination Containing 100 mg. of Dioctyl Sodium Sulfosuccinate and 1.0 mg. of Diacetyldihydroxy-phenylisatin per Tablet

Case	Age	Sex	Primary Diagnosis	Daily Dose (tabs.)	Days of Treatment	Over-all Result	Side Effects	
							DDP Dose 2.5 mg. or less	DDP Dose over 2.5 mg.
1	22	F	O	2	14	E	O	—
2	23	F		2	7	E	O	—
3	36	F	D,As	2	14	E	O	—
4	37	F	O	2	14	E	O	—
5	37	F		2-3	14	F	—	Straining
6	38	F		2	14	G	O	—
7	38	F	Cy	1-2	14	F	O	—
8	39	M		2	14	E	O	—
9	40	F	O	2	7	G	O	—
10	40	F	O	1	14	E	O	—
11	41	M	L	2	28	F	O	—
12	42	F	O	2	14	E	O	—
13	42	F	Cy	2-3	14	F	—	Flushing
14	43	F	M	2	14	E	O	—
15	44	M	O	2	14	E	O	—
16	45	F	Ho,O	2	14	E	O	—
17	46	F		2	7	P	O	—
18	47	F		2	7	F	O	—
19	47	F	O	2	14	G	O	—
20	49	F	O	2	14	E	O	—
21	52	F	Ho,M	2	14	G	O	—
22	54	M	U	2-4	14	P	O	O
23	55	F	As	2	14	E	O	—
24	56	F		2-3	7	G	O	O
25	56	F	Hy	4	14	P	—	Cramps
26	56	F	As,O	2	14	P	O	—
27	57	F	Hv	2	10	E	O	—
28	60	M	Ar	2	14	E	O	—
29	61	F	Hv	2-3	7	P	—	Cramps
30	62	M	Ao	2	7	E	O	—
31	62	F	An,As	2	21	E	O	—
32	63	M	Hv	2	14	E	O	—
33	65	F	Ao,As	2-3	7	F	—	Griping
34	65	M	Hm	2	14	E	O	—
35	66	M	H	2	5	P	O	—
36	69	F	Ha,G	2	14	E	O	—
37	72	F	Hv	3-5	14	P	—	O
38	76	F	H	2-4	14	F	O	O
39	80	F		2	5	P	O	—
40	82	F		1	14	E	O	—

a majority of these patients received treatment for constipation incidental to the management of a primary complaint unconnected with it.

In this series of patients, over-all results were recorded as excellent, with bowel movements normal in frequency and consistency, in 31, or 54.4 per cent; good, with considerable but not complete improvement, in 8; fair, with some improvement, in 10; and poor, with no improvement, in 8, or 14.0 per cent. When results with this medication were compared with those obtained previously by the same patients using a large variety of laxatives, effectiveness was greater in 87 per cent, the same in 10 per cent and less in 3 per cent of the patients. The general impression received from the use of this combination was that it is more effective than an equal dose of the stimulant medication alone, and considerably more beneficial than the detergent alone, in either of the two dosages used.

No side effects were noted in patients receiving the average dose of the stimulant, DDP, 2.5 mg. or less. DSS, being inert, has no bearing on the incidence of side effects, irrespective of the dosage

Table 2. — Results of Treatment of Chronic Constipation With a Laxative Combination Containing 100 mg. of Dioctyl Sodium Sulfosuccinate and 2.5 mg. of Diacetyldihydroxy-phenylisatin per Tablet

Case	Age	Sex	Primary Diagnosis	Daily Dose (tabs.)	Days of Treatment	Over-all Result	Side Effects	
							DDP Dose 2.5 mg. or less	DDP Dose over 2.5 mg.
1	21	F	Cy	2	14	F	—	O
2	22	F	As	2	14	G	—	O
3	33	F	O	2	11	E	—	O
4	34	M	Hm	2	11	F	—	O
5	43	F	S	2	14	E	—	O
6	43	F	O	2	14	E	—	O
7	46	F	As,O	2	14	E	—	O
8	51	F	Ao,O	2	11	E	—	O
9	59	F	H	2	14	F	—	O
10	60	F	O	2	14	E	—	O
11	62	F	O	2	14	E	—	O
12	62	F	Cr	2	12	G	—	O
13	63	M	H	2	7	E	—	O
14	68	F	E	2	14	E	—	O
15	70	M	H	2	14	G	—	O
16	75	M	Cv,D	2	14	E	—	O
17	84	M	Hv	2	14	E	—	O

Explanation of Symbols

Over-all result (see text): E—Excellent; F—Fair; G—Good; P—Poor

Primary Diagnosis: As—Anemia, secondary; An—Anorexia nervosa; Ao—Arthritis, osteo-; Ar—Arthritis, rheumatoid; Cr—Cardiorenal disease; Cv—Cerebrovascular accident; Cy—Cystitis; D—Diabetes; E—Emphysema; G—Glomerulonephritis; Ha—Heart failure; H—Hypertension; Hm—Hypertension, malignant; Hv—Hypertensive CVD; Hy—Hyperthyroidism; Ho—Hypothyroidism; L—Lumbar osteomyelitis; M—Menopausal syndrome; O—Obesity; P—Pregnancy; S—Salpingo-oophoritis; U—Ulcer, duodenal

used. Gastrointestinal side reactions, such as cramps or straining, were present in four patients of a total of 26 who received more than this dose daily, and flushing of the face was reported by one.

It can be concluded that the advantage deriving from the synergistic use of a detergent is lessened if excessive doses of a stimulant laxative are used. For this reason, the dosage should be standardized at 2.5 mg. of DDP with 100 mg. of DSS at bedtime, increased to double this amount in particularly resistant cases of constipation.

The average latent period between ingestion of the drug and the first bowel motion was 10 hours for initial use, and then gradually decreased to about eight hours as treatment progressed. This made it possible for the patient to take the medication at bedtime and produce a satisfactory bowel movement the following morning.

Although constipation was not related to the primary complaints of these patients, its successful treatment was often helpful in the management of these difficulties, particularly in cases of obesity, congestive failure and hypertension. This beneficial effect appeared to be both physical and psychologic, but relief from the pressure changes accompanying straining may have been a significant factor in patients suffering from cardiovascular diseases. Careful evaluation of the patient with an accurate appraisal of physiologic factors is a necessary requisite for treatment. The effect of other medications for the treatment of the primary conditions had little bearing on the results obtained.

Even in those patients who live at a fast rate with tensions and are frequently constipated, fine results were noted.

Summary

A clinical trial of a new laxative combination is reported. This medication consists of a detergent, dioctyl sodium sulfosuccinate, and a reduced

dose of a stimulant laxative, diacetyl-dihydroxyphenylisatin. The combination appears to be as effective as full doses of the peristaltic stimulant, with a lesser incidence of gastrointestinal side reactions, and markedly more effective than the detergent alone.

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Practical Points in the Surgical Management Of Congenital Hemolytic Anemia

Report of Two Cases in Siblings

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The first successful splenectomy for congenital hemolytic anemia was performed by Spencer Wells[1] in 1887. This curative procedure antedated the description of this disease by Murchison[2] in 1885. In 1910, Mayo[3] reported four cases of congenital hemolytic anemia treated successfully by splenectomy and predicted the operative success of this procedure in "many of the anemias and associated blood states." The wisdom of splenectomy in these early cases of congenital hemolytic anemia has been borne out and well documented by subsequent experience.[4] The current results of surgical treatment are uniformly good with an over-all mortality below 3 per cent.[5] The recent surgical management of two cases in siblings is noteworthy. Short abstracts of these cases follow.

Report of Cases

Case 1. — A 17 year old white man was referred because of anemia and an inguinal hernia which had resulted in rejection for the armed forces. His past history revealed a known mass in the right groin since age 10. Approximately one year before admission to the hospital he had noticed weakness which prevented his normal daily activities. There had also been dyspnea on exertion for the preceding month.

On examination, there was a soft systolic murmur present at the cardiac apex. The sclerae were icteric. A rounded, slightly tender spleen was palpable three finger breadths below the left costal margin. There was a moderate-sized, complete indirect inguinal hernia on the right side.

Laboratory findings included a hemoglobin estimation of 8.8 Gm. with 2.90 million red blood cells per cubic millimeter. Spherocytes and polychromatophilic cells were present on the direct blood smear. The result of the total van den Bergh test was 3.74 mg. per hundred cubic centimeters with a direct component of 0.54 mg. and indirect of 3.20 mg. The icteric index was 17.3. The Coomb's test gave negative results in both direct and indirect reactions. The red blood cell fragility test, without incubation, revealed initial hemolysis at a 0.42 per cent solution of sodium chloride and complete hemolysis at 0.32 per cent. After incubation the initial hemolysis was at 0.50 per cent, and hemolysis was complete at 0.36 per cent. The control showed initial hemolysis at 0.42 per cent and complete hemolysis at 0.32 per cent both with and without incubation. Because of the rather severe anemia in this case, a preoperative blood transfusion was administered the day prior to operation. After careful typing and subtyping, no major or minor agglutinins were discovered. Fresh whole blood was administered without evidence of transfusion reaction.

On Aug. 23, 1956, the patient was operated upon by one of us (GBC), and the spleen was found to be congested and enlarged several times normal size. It measured 21 by 12 by 5 cm. and weighed 1,030 Gm. No accessory splenic tissue was discovered. The gallbladder contained several pigment type calculi, each measuring approximately 10 by 8 mm. It was thin-walled and showed no evidence of chronic infection. The cystic duct was narrow, and there was no dilatation of the common bile duct. A cholecystostomy was performed with removal of all calculi and primary closure. A single rubber tissue drain was placed in the subhepatic area. The patient's condition was stable, and the inguinal hernia was accordingly repaired through a right inguinal incision of transverse type. On the fifth postoperative day the hemoglobin estimation was 13.5 Gm. and the red blood cell count 4.64 million per cubic millimeter. The spleen was reported as typical of hemolytic icterus, and the gallstones were of the pigment type.

The patient was discharged on the fifth postoperative day after a completely uneventful postoperative

course. It might be added that growth, appearance, and development increased remarkably in this patient, and a definite sense of well-being followed splenectomy. The systolic murmur at the apex had disappeared on follow-up visits. The patient was subsequently accepted for the armed forces.

Case 2. — A 20 year old white woman had been hospitalized in 1955 and 1956 because of pain in the upper abdominal region with jaundice. The jaundice had been present ever since the patient or her family could remember. The abdominal pain had occurred periodically for the preceding four years. The bouts of severe jaundice seemed to follow infections of the upper part of the respiratory tract. A younger sibling had been successfully treated by splenectomy for similar complaints (case 1). Her father was also known to have been jaundiced periodically for a number of years. There was a history of the onset of rheumatic fever at the age of nine years, requiring 30 days' hospitalization.

Positive physical findings included a distinct icteric color of the sclerae and a palpable spleen on deep inspiration. Roentgenograms of the gallbladder revealed a nonfunctioning gallbladder with cholelithiasis. Laboratory studies were obtained. Total serum proteins and the albumin-globulin ratio were normal. The van den Bergh test showed a total of 6.60 mg. per hundred cubic centimeters, direct reacting 0.9 mg. and indirect 5.7 mg. The hemoglobin estimation was 10.6 Gm., the hematocrit determination was 30, and the white blood cell count and differential count were normal. Spherocytes and polychromatophilic cells were present on the peripheral blood smear. The result of the cephalin-cholesterol flocculation test was 4 plus at 24 hours. The red blood cell fragility test, after incubation at 37 C. (98.6 F.) for 12 hours, showed initial hemolysis in a greater than 0.5 per cent solution of sodium chloride and complete hemolysis at 0.46 per cent. The control revealed initial hemolysis at 0.42 per cent and complete hemolysis at 0.32 per cent.

On Jan. 30, 1958, one of us (VBA) removed an enlarged congested spleen through a left subcostal incision. The spleen measured 16 by 12 by 5 cm. and weighed 510 Gm. A search for accessory splenic tissue was unrewarding. The gallbladder was thick-walled and filled with a single confluent stone. The common bile duct and cystic duct were small, and no stones could be palpated in the common bile duct. The liver was enlarged and congested with a deep purple hue. A cholecystectomy and liver biopsy were performed uneventfully. A single rubber tissue drain was placed in the subhepatic space and brought out through a stab wound in the right lateral portion of the abdomen. The pathologic report was: (1) spleen of hemolytic icterus; (2) chronic cholecystitis with calculi of the pure pigment type; (3) liver tissue showing chronic cholangitis with accumulation of lymphocytes in the portal areas. The parenchyma of the liver was normal.

The postoperative course was uneventful, and the patient was discharged on the fourth postoperative day. The hematocrit determination, prior to discharge, was 32. The patient received no blood during this hospital admission. She experienced a definite sense of well-being as soon as recovery from the operative procedure was complete.

Discussion

Several points of practical importance arise in the diagnosis and management of congenital hemolytic anemia:

1. The diagnosis must be considered in any child or young adult with cholelithiasis or splenomegaly. Laboratory findings offer conclusive evidence of this disease if properly conducted. Routine red blood cell fragility tests may be inconclusive (case 1) if incubation at 37 C. (98.6 F.) is not carried out for 12 to 24 hours prior to reading the extent of hemolysis. Normal red blood cells hemolyze in a 0.45 to a 0.2 per cent solution of sodium chloride. Cells from patients with congenital hemolytic anemia disintegrate at higher concentration, and hemolysis is usually complete at 0.4 per cent. Hyperplasia of the erythroid elements in the bone marrow is present, and the peripheral blood smear reveals spherocytosis and polychromatophilia. The Coomb's test is nonreactive for circulating antibodies, and this test may help differentiate hemolytic anemias of the acquired type.

2. Cholelithiasis coexists in approximately one third of the patients according to Orebaugh and Coller[4] and in 40 to 70 per cent according to Allen.[5] Simultaneous cholecystectomy, when indicated, is usually performed through the same incision if the patient is in good general condition. We have found a left upper quadrant incision of a subcostal type to be satisfactory in most cases. Although splenomegaly is commonly present in a mild to moderate degree, the spleen may usually be removed comfortably through this incision. In cases in which the spleen is greatly enlarged, a left thoracoabdominal incision might prove more advantageous.

3. ACTH and cortisone are temporary in value and unnecessary in most cases. Steroids may prove useful in the management of hemolytic crises or secondary hypersplenism following prolonged splenomegaly.[4]

4. These patients seemingly tolerate moderate degrees of anemia fairly well. Preoperative blood transfusions are best delayed unless severe anemia or hemolytic crisis exists. If necessary, blood may be administered following interruption of the blood supply to the spleen. Transfusion reactions are more common in these patients and transfusion may precipitate a hemolytic crisis. If such occurs, ACTH and cortisone along with carefully screened blood transfusions and supportive measures may arrest the situation. Splenectomy must occasionally be carried out as an emergency procedure during crisis if these measures prove fruitless.

5. Careful search for accessory spleens must be carried out in all cases, since 12 to 15 per cent of patients may be expected to have accessory splenic tissue.[5]

Summary

Although not rare, congenital hemolytic anemia is sufficiently uncommon to warrant the reitera-

tion of certain practical points. These are numerically enumerated in the foregoing discussion. Splenectomy offers uniformly good results of a permanent type since the cause of the excessive destruction of spherocytes has been corrected. Although spherocytosis and increased fragility commonly persist following splenectomy, the anemia and symptoms resulting from increased blood destruction are permanently relieved in practically all cases. The morbidity and mortality following splenectomy for this disease are extremely low and consistently below those following splenectomy for most other causes.

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Recent Changes in the Treatment Of Tuberculosis

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To discuss recent changes in the treatment of disease is always difficult. Physicians are working on the borders of knowledge where much is unproved and uncertain and where opinions shift, almost from day to day. I am sure it will be realized that all recent changes in the treatment of tuberculosis are not necessarily improvements and that my conclusions are personal and tentative assessments of questions for which the facts permit no definite answers.

Effective Drug Therapy

Drug therapy remains the basis of the treatment of tuberculosis and it is now almost universally accepted that isoniazid should be included in every drug regimen. Beyond this, there is little agreement.

Some think that isoniazid should be given routinely in dosage of 10 mg. per kilogram of body weight per day or more with pyridoxine added to protect against isoniazid-induced neuritis.[1] Others think that 5 to 6 mg. of isoniazid per kilogram of body weight per day is adequate dosage for the great majority of patients if para-aminosalicylic acid (PAS) is given concurrently and that it is worth while to avoid the necessity for pyridoxine, which is an expensive drug.

There are those who believe that if low dosage isoniazid is to be used for most patients, then blood levels of active isoniazid should be determined routinely at the beginning of treatment so that those patients in whom isoniazid is inactivated rapidly may be identified at the outset and treated with higher dosage of the drug.

Some believe that early in the course of drug treatment, streptomycin in dosage of 1 to 2 Gm. daily should always be included in the regimen.[1] Others believe that the improvement in results to be anticipated from such a regimen, if there be any improvement at all, will be too small to compensate for the increased toxicity and discomfort from such use of streptomycin.

A recent and still unpublished study suggests that streptomycin and pyrazinamide for four months or longer followed by isoniazid and PAS will give results superior to those from any other regimen yet subjected to large scale testing.[2]

Perhaps it is reasonable to conclude that with presently available drugs one is unlikely to find one regimen ideal for all patients. For example, perhaps a patient with minimal disease and intractable intolerance for PAS may be treated best with isoniazid alone. Perhaps a patient with a moderate amount of recent disease without extensive cavitation can be treated with most comfort and least risk with moderate dosage isoniazid and PAS, if it is first determined that he is not

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Director, State Tuberculosis Board.
Read before the Florida Health Officers' Society, Bal Harbour, May 11, 1958.

a rapid inactivator of isoniazid. And perhaps the patient with far advanced disease with extensive cavitation should be started on a regimen which will include daily streptomycin. At least it seems likely that some degree of individualization of drug regimens is reasonable.

As usual, several drugs effective against tubercle bacilli are being investigated. Among them are cycloserine, streptovaricin and thiocarbanidin. While some of these drugs are useful for an occasional patient with bacilli resistant to the commoner drugs who has an exacerbation of tuberculosis or requires resectional surgery, there is no evidence that any of them will play a part in the treatment of the usual patient.

The greatest recent advance in the treatment of tuberculosis is the demonstration that, with effective drug coverage, the use of corticosteroids is safe and effective in tuberculosis patients. To my mind it has already been conclusively demonstrated that such treatment may be life-saving for the patient critically ill with widespread, acute pulmonary tuberculosis or tuberculous meningitis.[3,4] It has not yet been demonstrated that steroid therapy will improve the results of treatment of patients who are not critically ill but who have far advanced pulmonary disease or tuberculous meningitis with less severe symptoms. Several controlled studies to elucidate this point are being made in the Florida State Tuberculosis Hospitals and elsewhere. It seems reasonable, and there is some evidence to suggest, that steroid therapy will be useful in the treatment of tuberculous pleurisy with effusion, tuberculous pericarditis and tuberculous peritonitis. It does not seem likely that such treatment will be helpful for the usual patient with pulmonary disease.

Selection of Patients

Not only is there debate about how tuberculosis patients should be treated, but there is still debate about what patients should be treated or, perhaps better, about what constitutes a tuberculosis patient. There is now rather general agreement that infants under one year of age with a positive tuberculin test should be treated with isoniazid because such treatment will reduce by 80 per cent the incidence of extrapulmonary complications, particularly meningitis. Perhaps most would extend this age limit from one year to three years. There is also almost general agreement that children of any age with x-ray evidence of disease should, like adults, receive antituberculosis drugs.[5]

There is much disagreement about the treatment of older children and adults with recently "converted" tuberculin tests. On the one hand, there is the expectation that such treatment will prevent the development of overt disease as it has been demonstrated to prevent the development of extrapulmonary tuberculosis in very young children. On the other hand, there is the fear that such treatment will not only fail to eradicate the infection but will materially interfere with the development and persistence of acquired immunity and will thus leave the patient more susceptible to future trouble than if he had not been treated. To me it seems that this danger is most unlikely since, in all probability, acquired immunity has developed before the positive tuberculin reaction is discovered, but certainly the question has not been settled by any adequate test.

Finally, there are some who would treat every person with a positive tuberculin test, whether recently acquired or not, and some who would treat everyone in contact with known tuberculosis, whether tuberculin positive or negative. I know of no convincing evidence as yet that such treatment is useful.

Changes in Auxiliary Methods of Treatment

There has also been continuing change in the auxiliary methods of treating tuberculosis. The use of rigid bed rest without bathroom privileges has almost completely disappeared except for the occasional patient who is too sick to get out of bed. Some now believe that rest is detrimental in that it will diminish the percentage of the bacterial population that are actively multiplying and are therefore susceptible to the action of drugs.[1] A controlled study in young men has shown that with pleural effusion only or with minimal, moderately advanced or far advanced pulmonary disease 23 hours of bed rest daily does not improve the results of treatment as compared to 12 hours of activity including mild outdoor games such as croquet and miniature golf.[6] In a small study of adult women with recent moderately and far advanced disease treated alternately with flat bed rest except for four bathroom privileges daily and a back rest for meals and 12 hours of enforced up-time, there was no detectable deleterious effect from activity.[7]

Since the results of hospital treatment of pleural effusions and minimal pulmonary tuberculosis are almost completely satisfactory without restriction of activity, it seems unlikely that bed rest can be expected to improve these results. Perhaps the same reasoning applies to most patients with moderately advanced disease. It has not yet been shown, however, to my satisfaction, that bed rest is not helpful in the treatment of patients with recent, far advanced disease with extensive cavitation, and it is in that group that I would expect any favorable results of bed rest to be most evident.

Like strict bed rest, the use of temporary collapse therapy, pneumothorax and pneumoperitoneum, has almost disappeared in the United States, although such treatment finds more advocates in Europe. There is still a small minority in the United States who think that pneumoperitoneum is indicated for patients with far advanced exudative disease with extensive cavitation, and I, myself, believe there is still, although infrequently, an indication for pneumothorax, for example, in a patient with recent disease and with an absolute contraindication to resectional surgery who still has cavity and tubercle bacilli in the sputum after an adequate trial of drug therapy.

Resectional Surgery

The place of resectional surgery in the treatment of tuberculosis is also being reduced. On the one hand, it has been rather generally accepted that the resection of small residual lesions without cavity does not offer appreciable protection from subsequent relapse.[8,9] At the other extreme, patients with regular, thin-walled cavities whose sputum has been free of tubercle bacilli on frequent cultures for a year or longer and whose drug treatment has been continued have shown a relapse rate sufficiently low so that resection is no longer advised for such patients if the risk of surgery seems appreciably greater than usual.[10-13]

Test for Antibodies in Blood Serum

On the horizon of changes in the treatment of tuberculosis is a test for antibodies in blood serum, recently announced by Dr. Youmans and his associates in Chicago, which shows some promise of differentiating between active and inactive tuberculosis.[14] Laboratory tests with this purpose have been disappointing in the past but, if this one should prove reliable in large scale tests which are now being planned, it will certainly be most helpful in the study of patients with questionably active tuberculosis and in the differential diagnosis of pulmonary disease. In addition, it may sharpen the ability to judge properly the indications for resectional surgery and it may aid in determining the proper time for discharge from a tuberculosis hospital.

Altogether, the failures of tuberculosis treatment are now almost confined to those patients who are very old or who are admitted with far advanced disease. This, of course, makes improvement of tuberculosis case finding even more urgent than it has been in previous years. Also, the number of patients discharged alive, each with a small but definite chance of relapse, increases each year, and each such patient urgently needs follow-up examinations, particularly bacteriologic examinations. As the work of the hospital in tuberculosis control becomes easier, the work of the Health Officer becomes at once more difficult and more important.

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ABSTRACTS

The Effect of Prednisone in the Prevention of Esophageal Stricture Following the Ingestion of Lye. By W. W. Cleveland, M.D., N. Thornton, M.D., J. G. Chesney, M.D., and R. B. Lawson, M.D. South. M. J. 51:861-864 (July) 1958.

In this study of the value of steroid therapy in the treatment of lye burns of the esophagus, 23 patients who had ingested lye were managed on a therapeutic regimen including prednisone and tetracycline. Stricture developed in three of 14 patients receiving full treatment, and in two of four receiving less than the full program of steroids. In five patients started on this program with discontinuation of prednisone after esophagoscopy gave negative results, stricture did not develop. Complications included a perforated gastric ulcer and two instances of perforation of the esophagus.

The authors conclude that this study does not conclusively establish the value of prednisone in preventing stricture of the esophagus, but they regard the results obtained as sufficiently encouraging to warrant pursuit of the study in patients shown by early esophagoscopy to have burns of the esophagus.

Testosterone Pellet Implants for Advanced Breast Carcinomatosis in the Female. Preliminary Report. By Carlos P. Lamar, M.D. and Philipp R. Rezek, M.D. J. Am. Geriatrics Soc. 6:397-404 (May) 1958.

In this preliminary report the authors present clinical and pathologic observations made within the last 10 years upon a group of 100 women treated by subcutaneous implants of testosterone pellets for palliation of advanced and otherwise intractable cancer of the breast. Testosterone (pure crystalline) compressed pellets (75 mg. each) were implanted, 10 at a time, into the subcutaneous fat through a special trocar. Implants were made at weekly intervals for six or more times and then spaced farther apart, up to twice a year in a patient who survived for more than eight years, and three to six times a year in other patients who survived for periods ranging from three to six years. Implants of pure testosterone have the advantage of more prolonged effect and less frequent administration than intramuscular injections of testosterone esters.

Masculinizing changes seemed to be less conspicuous than with other forms of less intense androgenic therapy. Edema was minimal, and there was no hypercalcemia. In two cases tetanic muscular contractions were relieved by parenteral administration of calcium. As a rule serum levels of protein, calcium, phosphorus, and alkaline and acid phosphatase remained within normal limits. Exacerbations of neoplastic activity were accompanied occasionally by a transient increase in the serum levels of alkaline and acid phosphatase, and more frequently by an increase in serum protein-bound iodine concentration and thyroidal I^{131} uptake along with decreased glucose tolerance. Subjective responses were good in over 90 per cent of the patients, as manifested by reduction or even suppression of severe pain, production of euphoria, and gain in appetite, weight and strength. The duration of remissions ranged from eight weeks to eight years, averaging 28 months. Case histories illustrate gross and histologic changes observed and the relatively low incidence of masculinizing changes.

The Debated Indications for Vaginal Hysterectomy. By James M. Ingram, M.D., Robert W. Withers, M.D., and Henry L. Wright, M.D. South. M. J. 51:869-872 (July) 1958.

Citing symptomatic pelvic relaxation, functional uterine bleeding resistant to treatment and small symptomatic myomas as established indications for vaginal hysterectomy, the authors observe that less frequent indications provide the most interest, and at times dispute, among gynecologists at the present time. The acceptance of these indications varies from place to place and from year to year, they note, but they cannot be called "borderline indications" because they are completely accepted by some and vigorously rejected by others. The purpose of this paper is to examine and evaluate these debated indications for vaginal hysterectomy. The discussion is presented under the headings of intraepithelial carcinoma of the cervix, endometrial carcinoma, symptomatic retroversion, resistant cervical erosion, sterilization by vaginal hysterectomy, young

multiparas with relaxation, and myomas requiring morcellation. Vaginal hysterectomy is not presented as a surgical pelvic panacea, but its increased use is advocated because of its relative safety and wide adaptability.

The Role of Cyclodiathermy in the Treatment of Glaucoma. By Sherman B. Forbes, M.D. South. M. J. 51:770-777 (June) 1958.

In an effort to establish the role of cyclodiathermy in the surgical treatment of glaucoma, the author reports a series of 101 cases in which 167 eyes were treated one or more times by this method. The results confirm the efficacy of this procedure as demonstrated in a previously reported series. The surgical procedure employed is described.

This operation is advocated as a safe and effective method of treating primary glaucoma of the wide angle type. In the series presented this measure alone was employed successfully in the treatment of 49 of the 59 eyes in Negro patients and in 41 of the 51 eyes in white patients with this type of glaucoma. In the remaining 17 eyes in this group, this treatment was combined with other operations and/or miotics with success in all but five, or less than 5 per cent. Cyclodiathermy is also advocated in the treatment of various forms of secondary glaucoma and in congenital glaucoma. Its use is discouraged in the very narrow angle type of glaucoma and in microphthalmic eyes.

Some Physical Chemical Properties of Urine in Patients with Calcium-Containing Renal Calculi. By Arthur J. Butt, M.D. F. A.C.S., F.I.C.S., D.A.B., and Reid H. Leonard, Ph.D. J. Internat. Coll. Surgeons 30:55-60 (July) 1958.

In this study the authors report quantitative analyses of renal stones from 450 patients in the West Florida "stone belt" which revealed that 89 per cent contained more than 15 per cent calcium and that 79 per cent were compounds of calcium oxalate and calcium phosphate. Chemical analyses of calcium-containing calculi indicated that it is calcium cation which is important.

A method is presented for assaying the calcium-binding capacity of urine. From this, curves can be plotted that are characteristic of every urine specimen encountered.

Titrations of mixtures of monopotassium phosphate and glycine will produce curves closely resembling those obtained in urine. From this it is postulated that the great excess of phosphorus in urine may act in part by combining with an amino acid to stabilize the calcium.

Autogenous Ovarian Transplant Into the Fundus Uteri; Report of Case. By Daniel H. Rowe, M.D., F.A.C.S., F.A.C.O.G., D.A.B., and George C. Douglas, M.D., A.I.C.S., F.A.C.O.G. J. Internat. Coll. Surgeons 29:734-739 (June) 1958.

The purpose of this article is to report a case of ovarian transplant and to present a brief review of the literature on this subject. Of the various sites for grafting, the authors prefer the uterine musculature because it has a good blood supply, the likelihood of tenderness over the areas of implantation is not so great as in the rectus muscle, and the uterine fundus is most easily accessible when the abdomen is already open. They regarded the transplant in their case completely successful as the patient's previously normal menstrual cycle was re-established and no signs of ovarian deficit were apparent after four full years. The latent period of two full months substantiated the premise that no ovarian tissue was hidden from view. While they consider ovarian autografting as no substitute for any conservative measure, they observe that to the occasional patient on whom bilateral oophorectomy has been performed for one reason or another, this procedure offers certain advantages. It will delay the onset of the menopause, and, if the uterus is intact, with at least one tube, there is the rare possibility that pregnancy may occur if the site of the autograft makes the peritoneal cavity accessible thereto. In addition, if the menopause should occur in the not too distant future, its approach would probably be more gradual and more nearly normal than if it depended entirely on substitution therapy. They recommend utilization of the posterior wall of the uterine fundus as a recipient area for ovarian transplantation.

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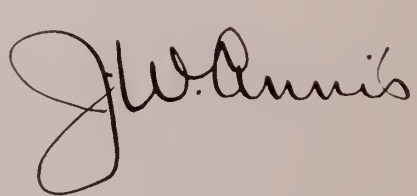
PRESIDENT'S PAGE

Beware the Ides of March!

Early in this same rebellious month, 2003 years ago, the small, thin voice of a soothsayer reached the ear of mighty Caesar and gave him pause—but only for a moment. Without drawing analogies, contemplate, if you will, the qualities that led to Caesar's downfall. Here was diligence, discipline and dedication. Here was singleness of purpose and devotion to the State. Here was courage and conviction; but here, also, was arrogance and smug self satisfaction. Here a pompous assurance, bred from long accustomed power and position—an impatient contempt of opposition or delay—an imperious disregard for advice and suggestion—and here, too, that curiously frequent lack of understanding and awareness of a smoldering discordant rumbling amongst the populace. Here was the blind intolerance of isolation; the unwillingness to listen to and be guided by the uninitiated—to recognize and examine each new point of view. Here was the vulnerability of dogma, protocol and self esteem—the assurance of rectitude—the lack of respect for experiment. . . . And so Caesar fell.

The tragedy of Caesar was also the tragedy of Brutus: honest, misguided, half-informed—and even more the tragedy of the citizens of Rome—the little men who, led by the yapping dogs, the braying asses, and the viciously screaming, jealous jackals, perpetrated the treachery that destroyed an economy, and threw a State into civil war. This was a destructive, not a progressive attack, on the status quo. This was a radical attempt at improvement through bloody and ill-conceived rebellion. But this, also, has ever been the course of history.

And perhaps it behooves all of us, in our lives and in our professions, to recall annually, during this turbulent month, great Caesar's fall, lest we forget that, neither individually nor collectively, can we afford to approach our problems blindfolded by bigotry, deafened by arrogance, or drugged by the mores, ideologies and precedents of another age that are no longer applicable in our time. Let us look about us more discerningly than did Caesar.



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Myxedema

The art of clinical management is the traditional foundation for the practice of medicine. Recent emphasis on spectacular operative and laboratory methods, important as they are, have tended to overshadow the simpler but equally important methods requiring only the physician's brain and hands. No clearer example exists of a disease in which the diagnosis and treatment can be adequately managed by clinical methods than the frequently overlooked controllable condition—myxedema. It is important that the condition be recognized since therapy will prevent development in the patient of serious irreversible complications.

The diagnosis can be made in the consultation room. The hint of the existence of myxedema may come from any system in the body; hence, the diagnosis may be made by any specialist or by the general physician. The onset is slow and insidious; symptoms have usually been present an average of six years before the clinical diagnosis is made. Women are much more frequently affected than men, though the reason for this difference is unknown. The patient may complain of intolerance to cold, requiring more clothing and bed covers than other members of the family, constipation, or disturbances in menstruation. Women complain of thin brittle nails and dry brittle hair, and note that they rarely have to pluck their eyebrows. Men find that they do not have to have haircuts as frequently as in the past, often going months rather than weeks between visits to the barber. The growth of hair is suppressed not only on the scalp but in the beard, on the extremities and in the axillary and pubic areas. While the history is being elicited, the physician will be struck by the froglike quality of the voice, its low pitch, and the slowness of speech. The response of the mind also is slowed; the reaction time is prolonged, but the sense of humor is usually retained in a dry characteristic fashion.

The face is puffy with coarsening and thickening of the features as well as swelling of the eyes. The reduced secretion of sweat and sebaceous glands results in a cool, dry, scaly skin which often lacks resiliency. The peripheral pulsations are slow and diminished in volume. Heart sounds are distant and of poor quality, lacking the snapping muscular sound of the normal heart. In long-standing cases the peripheral arteries become thickened and markedly arteriosclerotic. Serious

effusions may appear in the pleural, peritoneal, or pericardial cavities. A simple diagnostic sign which seems to be specific to myxedema is delayed relaxation of the tendon reflexes. This physical sign requires no apparatus to elicit; it may be detected in any tendon with the unaided fingers. Once the sign has been felt, it is instantly recognizable. The diagnosis can be confirmed by studies which measure the metabolism of iodine and its incorporation into circulating hormone, or the utilization of oxygen.

The findings in the history and the physical examination can be explained on physiologic changes which affect the growth and function of all cells. In addition to skin, hair, and nails, cells of the bone marrow grow slowly. Indeed the usual hypochromic anemia seen early in the course of the disease may become hyperchromic macrocytic as the bone marrow becomes hypoplastic. This disturbance in the blood can easily be confused with pernicious anemia; the cells of the gastric mucosa may secrete little or no hydrochloric acid, and the marrow does not respond to specific hematopoietic factors which induce dramatic changes in pernicious anemia.

Many changes are the result of disturbances in the utilization of food and the distribution of fluids. The thyroid hormone is an important regulator of the body's metabolism and determines the rate at which food is burned by the body for fuel. It is this function of the thyroid gland which has been studied most intensively in the past and is the basis for the commonly used clinical test of thyroid deficiency, the basal metabolic rate. The frequent symptom of intolerance to cold reflects the reduction in the number of calories produced by the body with the lowered consumption of oxygen. Food is poorly absorbed from the gastrointestinal tract so that the oral glucose tolerance test may show a low or flat curve. The hypochlorhydria helps to produce the symtoms of anorexia and indigestion. The incomplete utilization of vitamins is reflected in the carotenemia which is sometimes present and which contributes to the yellow tint of the skin. The disturbance in utilization of proteins is reflected in the abnormal materials deposited in the interstitial tissues which tend to hold edema fluid there. The disease in fact derives its name from this characteristic.

The disturbance in lipid metabolism leads to the early development of severe arteriosclerosis with permanent damage to the heart, brain and extremities. The blood cholesterol is usually above 300 milligrams per hundred cubic centimeters. The disturbances in lipid metabolism may progress to the point where fat is found in the liver on aspiration biopsy. Fluid is retained chiefly in the extravascular spaces. The puffiness of the face, coarsening and thickening of the features, swelling of the eyes, hoarse voice and difficulty in hearing are the result of excessive retention of fluid. Alterations in the contraction of myocardium and peripheral muscles are probably the result of altered distribution of fluids since these changes disappear rapidly in a matter of days simultaneously with a diuresis which begins after the institution of thyroid replacement therapy. Improvement in muscular function is evidenced by a shortened relaxation of the tendon reflexes and in the circulation by reduction in the size of the heart, increase in its rate and a reversion toward normal of electrocardiographic changes.

Therapy consists in the replacement of thyroid hormone. Even though the patient may be young in years, myxedema of long duration may cause his biologic age to be considerably greater than his chronologic age. Caution should be exercised in the dose of thyroid extract given. Since the effect of thyroid is cumulative, the starting dose should be small and need not be changed frequently, but should be increased gradually at intervals of two to four weeks. The maximum dose which should be required even for complete myxedema is 196 milligrams daily; if the patient is not relieved with that dose, the diagnosis should be seriously questioned. The patient should understand that the drug constitutes replacement rather than curative therapy. The patient should be cautioned to report to the physician immediately any symptoms suggesting angina which appear during therapy. The increased demands of the myocardium for oxygen and the inability of the coronary arteries to supply the necessary amount of blood are readily detectable by the history. Continuation of the same dose may be followed by a coronary occlusion; so the amount prescribed should be promptly reduced. It is possible by simple clinical methods to work out a dose which will relieve the most distressing subjective symtoms, correct most of the signs concerned with altered distribution of fluids, and yet not produce coronary insufficiency.

Supportive therapy in the form of vitamins and iron to supplement a good diet may speed up the disappearance of signs of nutritional deficiency from poor utilization of foods. When any drug

except thyroid is administered to patients with myxedema, it should be started in small doses and given very cautiously. These patients usually exhibit sensitivity to certain drugs, particularly quinine, morphine, and autonomic blocking agents. Because of the tendency of bromine to replace iodine in chemical molecules, bromides should not be used for sedation. The similar ability of the thiocyanate ion to replace iodide would contraindicate its use in myxedematous patients with hypertension. Since the sulfonamides are known to block certain enzymatic steps in the synthesis of thyroid hormone, it would be advisable to use antibiotics rather than sulfonamides when an infection occurs. If the disease is recognized early and treatment is carefully followed, the results in clinical management of patients with myxedema are among the most satisfying a physician can experience.

The Art of Purposeful Inactivity

It is perhaps a reflection of the age in which we live—the foreshortening of time by jet airliners, rocket missiles, and the like—that an immediate response should be expected of therapeutic measures. Which one of us has not been called by the impatient patient to report that the fever has not "broken" 12 hours after the first penicillin injection? And which of us can claim never to have switched medicines two or more times in a single day in a breathless rush to cure the patient?

There are indeed true medical emergencies where aggressive measures are required. There are a great many more instances where little or no drug therapy is needed, and where time and patience will effect a cure. It would be well for the physician to analyze his motives in prescribing for a patient, asking "Is he impatient, or am I?" Once a course of treatment is outlined, the doctor should practice the art of watchful waiting, alert to possible complications but content to wait placidly for results. It is not an art easily come by, as Osler stated in his "Aequanimitas:" "In a true and perfect form, imperturbability is indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease. With such advantages he is so equipped that no eventuality can disturb the mental equilibrium of the physician: the possibilities are always manifest, and the course of action clear." Such equanimity is by itself often a powerful therapeutic measure, serving to reassure and comfort the patient and his family.

The care of the chronically and incurably ill patient presents a special problem in purposeful inactivity. Here the physician may be inactive in prescribing drugs, but should exploit to the full all the physical measures that the family can carry out at home. These would include special diets, massage and passive exercises, and other such tasks which fulfil the need for positive action felt by the patient or his family. In addition, the physician should be aware of the comfort and support derived from his unhurried visit to the patient, especially if he will concern himself with the minute details of nursing care which loom so large to the bed-fast patient whose attention gradually becomes wholly centered on his bodily functions and discomforts. The doctor need make no changes in the treatment program; his concern

March Cover



The Temples and Cult of Asclepius

For nearly one thousand years, sick and afflicted pilgrims flocked to the Grecian Temples of Asclepius to take part in a ritual called incubation. If successful, the ancient, kindly god of medicine was expected to visit them during a dream-state and either heal them or prescribe modes of treatment, drugs and diet. Temples were set in favorable surroundings, much like spas and shrines of today.

(Courtesy of Parke, Davis & Company)

is what counts. Nothing can be more cruel or heartless than the statement, "You may as well save the money for my house-calls; there is nothing more I can do." There may be nothing more in an active curative sense that can be offered, but the implication of abandonment can shake the faith of the patient, the family, and indeed the community in the medical profession. The doctor must often be inactive, but his concern, perhaps expressed by a phone call but better yet in person, will prevent the charge of neglect.

The art of purposeful inactivity should also be practiced by the physician upon himself. For the body, sleep is the height of such inactivity. Our calling is such that sleep is prone to be interrupted, but opportunities to catch up on needed rest must not be neglected. Chronic fatigue is a threat to good health and impairs not only our relations with our families but also the judgment and skill with which we treat our patients. In addition, keep in mind the value of relaxing the mind and the emotions. For some this is best done by engaging in sports or other muscular exertion; for others gardening or fishing provides the periods of quiet contemplation which are essential. In this restless age, action of some sort often seems demanded. It takes courage, practice, and equanimity to do nothing, but inactivity based on reason and purpose can be most rewarding to the physician.

JOHN M. PACKARD, M.D.

Program for Scientific Assemblies
1959 Annual Meeting
Miami Beach, May 2-6

For its Eighty-Fifth Annual Meeting the Florida Medical Association will return to Miami Beach early in May and, as last year, hold its sessions in the Hotel Americana at Bal Harbour in the northern section of the city. The dates of the meeting are May 2 to 6, with specialty groups free to schedule their meetings on Saturday, May 2, the morning and night of Sunday, May 3, and also Tuesday night, May 5, since no annual banquet is scheduled for that night this year. The House of Delegates will hold its first session on Sunday afternoon, May 3.

As has been the custom for the last two years, there will be two scientific assemblies, both held on Tuesday, May 5. This schedule permits members who can attend for only one day to have the benefit of the excellent scientific program in its entirety.

Dr. Richard Reeser Jr. of St. Petersburg will preside at the opening session on Tuesday morning, which is scheduled to begin at 9:30. M. Michael Sigel, Ph.D., of Coral Gables will present the first paper, entitled "Polio-Like Diseases in South Florida." Dr. Nelson H. Kraeft of Tallahassee will then speak on "Spontaneous Pneumothorax: Its Complications and Treatment," and the third essayist will be Dr. Miles J. Bielek of Fort Lauderdale, whose subject is "Clinical Variations in Thyrotoxocosis."

At 11 a.m., following the morning recess, a symposium on "Cardiovascular Problems," with Dr. John M. Packard of Pensacola presiding, will conclude the session. The physicians who will participate and their subjects are: Dr. Clyde M. Collins of Jacksonville, "Problems Encountered in a Vascular Clinic;" Dr. David S. Hubbell of St. Petersburg, "Arterial Aneurysms: Florida's Problems;" and Dr. Paul W. Boyles of Coral Gables, "Experimental and Clinical Use of Intravenous Fibrinolysin Therapy."

The second session will convene at 2 p.m. with Dr. Franz H. Stewart of Miami presiding. Dr. C. MacKenzie Brown of Tampa will speak on "Facial Pain" and will be followed by Dr. Robert G. Steele of Sarasota, who has chosen "The Office Diagnosis of Masked Depression" for his subject. Dr. Thomas S. Edwards of Jacksonville will then present a paper on "Central Angiospastic Retinopathy, an Ocular Vasoneurotic Syndrome."

At 3:30 p.m., following the afternoon recess, a symposium on the "Third Greatest Cause of Death" will be presented as the concluding feature on the scientific program, with Dr. George T. Harrell of Gainesville presiding. The participants will be Dr. Paul W. Braunstein of New York, Surgical Consultant, Automotive Crash Injury Research Project, Department of Public Health and Preventive Medicine, Cornell University Med-





From left, M. Michael Sigel, Ph.D., Coral Gables; Nelson H. Kraeft, M.D., Tallahassee, and Miles J. Bielek, Fort Lauderdale.





From left, Clyde M. Collins, M.D., Jacksonville; David S. Hubbell, M.D., St. Petersburg, and Paul W. Boyles, M.D., Coral Gables.





From left, C. MacKenzie Brown, M.D., Tampa; Robert G. Steele, M.D., Sarasota; and Thomas S. Edwards, M.D., Jacksonville.






From left, Paul W. Braunstein, M.D., New York City; Frank E. Maloney, LL.B., Gainesville; Captain C. W. Keith, Tallahassee, and Mr. Harry C. Steed Jr., Atlanta.

ical College; Frank E. Maloney, LL.B., of Gainesville, Acting Dean, College of Law, University of Florida, C. W. Keith of Tallahassee, Captain, Florida State Department of Public Safety; and Harry C. Steed Jr. of Atlanta, Safety Engineer, Director, Accident Prevention Unit, Georgia State Department of Public Health.

Dr. Braunstein will speak on "Automotive Crash Injury Research." Dean Maloney has for his subject "Accident Proneness in the Automobile Accident Field." Captain Keith will discuss "Physical Impairments as They Relate to Accidents," and Mr. Steed's subject is "Accidents, A Family Problem."

The entire program for the Annual Meeting will be published in the April issue of The Journal. The excellent scientific program, the distinguished guests scheduled to speak at other sessions, the deliberations of the House of Delegates on matters vital to every member of the Association, and the attractions of the Hotel Americana, Miami Beach and the surrounding area should have wide enough appeal to result in a record attendance.

Citizens Medical Committee on Health Report Submitted to Governor

Meeting in Jacksonville on Jan. 10, 1959, the Citizens Medical Committee on Health gave careful consideration to the reports presented by the various subcommittee chairmen and then adopted its final report. This committee was created on April 4, 1958, by the Honorable Leroy Collins, Governor of the State of Florida, at the suggestion of the Florida Medical Association, to engage in appropriate studies and make recommendations with a view to providing Florida with the best possible health planning and services. The Governor designated Dr. Edward R. Annis of Miami to serve as chairman of this committee.

The areas chosen for study were: care of chronically ill and aged indigents; outpatient care of indigents; coordination and maximum utilization of state agencies rendering health services; role of volunteer health agencies operating in Florida; maximum utilization of personnel trained in the health field; and additional areas of study deemed advisable by the committee.

On January 11, the Summary Report, as adopted, was submitted to the Board of Governors of the Florida Medical Association. The Board gave its approval to the report in principle and expressed appreciation to the committee as a whole and to the individual members of the subcommittees for the expeditious and impressive manner in which they had accomplished their important task.

The report was presented to Governor Collins on January 22 and was received with enthusiastic interest. The Governor promptly gave permission for release of the report, which is now available for distribution upon request.

All members of the Florida Medical Association will find the entire report of particular interest. They will be kept informed as the Governor incorporates various recommendations of the report into his program on health. For their convenience the Summary Report follows in full:

Summary Report

Care of the Chronically Ill and Aged Indigents and Outpatient Care of Indigents

To accumulate the factual data needed for sound planning the staff of the Committee conducted extensive studies. Major findings are presented in the full report and the detailed data are in the files of the Committee. There was an examination of population distribution and trends; a review of plans used in other areas for the care of chronic illnesses and for the provision of health services to the aged, and an examination of auxiliary home services now available in Florida. In the study of medical care the nature of outpatient services in one of the major cities was examined fully. There was a detailed investigation of nursing homes and their patients, the first adequate study of this type in Florida. This involved collecting information on 330 of the state's 344 nursing homes, also individual personal, medical and financial data on 6,298 of the 6,567 known residents of the homes. There was an even more extensive study of hospitals conducted with the cooperation of the Florida Hospital Association. Medical and financial data were collected on 8,474 patients in 114 hospitals located in 65 counties. These represented a cross section of Florida's hospital population. Additional data

were elicited on 1,590 patients who remained in hospital for 15 days or more. This was a cross section of the approximately ten per cent who are long term patients in Florida's hospitals. Data on the present state program for the hospitalization of the indigent were reviewed also. In cooperation with agencies offering medical and health insurance, there was an exploration of possible plans for the provision of appropriate insurance to cover chronic illnesses and to meet the needs of the aged. In these studies there were the following observations which are particularly pertinent to the specific assignments of this Committee.

Population Data

Population trends indicate a Florida census in 1960 of 4.9 million with 9 per cent (400,000) aged 65 and over.

Almost 50 per cent of the men and 75 per cent of the women in this age group reported incomes of less than $1,000 in 1950. (This economic measure does not take into account other assets or the factor of relative responsibility.)

State Welfare recipients in Florida during the month of October 1958 in the four categories numbered:

Old Age Assistance	69,839
Aid to Dependent Children	26,171
Aid to the Blind	2,540
Aid to the Disabled	6,785
Total Recipients of Public Assistance	105,335

Nursing Home Study

Information obtained from 330 of the 344 licensed nursing homes in Florida revealed:

	Number of Beds
273 privately owned	7,061
38 nonprofit (including church related)	936
19 city or county institutions	510
Total	8,507

Nursing home median bed capacity	20
Total nursing home residents	6,567
Average age resident	79 years

Religious preference:

Protestant Denominations		74%
No preference	37%	
Baptist	21	
Methodist	16	
Presbyterian	7	
Episcopalian	6	
Lutheran	3	
Christian Scientists	2	
Remainder (17 other denominations)	8	
Catholic		11%
Jewish		5%
No preference		10%

Mentally— 1/3 Clear
1/4 Completely confused
Rest sometimes confused

Incontinence of bowel or bladder or both occurred in one third.

Less than one half were able to walk alone.

The average resident had been in the nursing home two years.

The median charge for nursing home care was $123 a month chiefly ranging from $70 to $500 a month.

The median drug cost reported was $15 a month.

Nursing home costs were paid from the following sources:

Patient and family	22.1%
Social Security	15.5
Insurance	1.1
Welfare-State	22.6
Welfare—County & City	35.7
Other	3.0

According to the opinion of the operators or senior nurses of the nursing homes, about one third of the occupants could be cared for in a home, if they had one, and if home nursing or other supporting services were available in the community.

Hospital Service for the Indigent Program

The Hospital Service for the Indigent Program is state-county financed and administered. Its purpose is to provide hospital services for indigent persons who are acutely ill or injured. An added objective is to stimulate all counties of the state to recognize and discharge their responsibilities for providing adequately for indigent residents. Participating counties are required to appropriate, annually, county funds of at least 50 cents per capita according to a current population estimate. State matching funds are available also.

In summary the activities of this program for the period October 1, 1957, through September 30, 1958, were as follows:

Effective October 1, 1958, all counties except Franklin, Gulf, Washington and Okaloosa were participating (effective for 97 per cent of State's population).

For the first six months of the current budget year, 10,483 hospital admissions, representing 101,020 patient days, were financed in whole or part by the program.

The average length of stay per hospital admission was 9.6 days at an average per diem cost to the program of $19.94, or an average cost of $191.42 per admission.

The average total cost for inpatient care to hospitals submitting data was $22.45 per diem.

For the period October 1, 1957, to June 30, 1958, (three-quarters) total funds expended amounted to $3,056,782, consisting of $1,686,603 county funds and $1,370,179 state funds.

Of all patients, 26 per cent were aged 65 or over. There was also a concentration of nonwhite females aged 25-34 who were admitted primarily for delivery or the complications of pregnancy.

In a sample of cases in which data were obtained from the State Welfare Department 46 per cent of those admitted were categorically indigent. The proportion varied from county to county; for example, in Pinellas County 59 per cent were categorically indigent in contrast to 31 per cent in adjoining Hillsborough. In only 10 per cent of the admissions was there participation in payment to the hospital by family or relatives, charitable organizations or insurance.

Based on previous studies it is conservatively estimated that the value of physicians' services given gratuitously for the care of indigents approximates the cost of hospitalization.

Hospital Studies

This study was designed to assemble information, including hospital cost, on a representative cross section of the total hospital population. Information was provided on a total of 8,474 patients in 114 hospitals located in 65 counties. Average length of stay was 6.7 days.

Length of stay of patients discharged:

1st week	73.6%
2nd week	16.6
3rd and 4th week	7.7
1 to 3 months	1.8
Over 3 months	.2

Nine and seven-tenths per cent of the total hospital population remained for longer than two weeks. Average length of stay of these long term patients was 90.4 days. Average total cost of hospitalization was $183.00 per case and tended to increase with age. The highest average cost was for those age 65 and over. This study revealed that 40 per cent of the long term patients did not need the specialized care of a general hospital.

Outpatient Care

Currently outpatient care is available only in the major cities. Hospital outpatient clinics were of substantial importance in making medical services available to the aged. In the area studied a relatively small percentage of those attending the clinics were categorically indigent. The remainder are classed as medically indigent by the social service department.

Hospital Insurance for the Aged

Sixty-three per cent of the population of all ages have health insurance; however, only 35 per cent of those 65 and over are insured.

Recommendations

1. For the extension of the benefits of health insurance: through every practicable channel encourage the development and promote the use of voluntary low cost health insurance which will extend benefits to the aged and cover long term illnesses.

2. For reduction in the costs of hospital care in long stay illnesses: the encouragement of the construction and operation of "limited service hospitals" in close proximity to major general hospitals to promote early transfer of patients from general hospitals and to provide efficient economical long term care of chronic diseases.

3. For more adequate nursing home care: legislative authorization for the Welfare Board to implement a program to pay the cost of nursing home care for public assistance recipients, this to be provided by county, state, and federal matching funds as outlined in House Bill 1561 of the 1957 legislature; also encouragement of the active participation of religious groups in developing and maintaining nursing home facilities.

4. For accessible and economical medical care for the aged and those with chronic illnesses: the expansion of present outpatient clinics and the organization of additional clinics to meet the medical needs of the indigent aged and the chronically ill, with such services coordinated with and fully utilized in expanding and strengthening the intern and resident medical training program.

5. For home care of the aged and the chronically ill: within the realm of existing health agencies to expand and modify community nursing programs so the services of visiting nurses will be widely available; welfare agencies to sponsor foster home care, and homemaker and friendly visitor services.

6. For extension of the Hospitalization of Indigent Program without added state or county tax funds: continue program at present level of state and local support with authorization for extending benefits to outpatient care of indigent for chronic as well as acute illnesses; expand budget through the development and adoption of acceptable plans whereby federal matching funds for medical care of the categorically indigent will be available to Florida for a program administered

as at present insofar as practicable (to finance the additional outpatient care).

7. For increased State and local responsibility for medical care of the indigent programs: use every possible influence to obtain a release to the states of tax sources now utilized by the federal government for the support of health services with planning and administrative responsibility centered as close as practicable to those served.

8. For promoting positive health in the aged: develop a pilot demonstration in one or more communities of a total comprehensive health program for the aged with strong emphasis on the maintenance and enrichment of the health of the senior citizens, involving broad coordinated participation of the medical profession, health department, hospitals, institutions and other community agencies.

9. For the accumulation of statewide budgetary data on health and welfare services: the evolution by the state auditor (in cooperation with appropriate county officials) of uniform budgetary accounting procedures covering public welfare, medical and health activities.

Coordination and Maximum Utilization of State Agencies Rendering Health Services

Information concerning the medical and health programs of 13 state agencies was assembled and reviewed in committee with representatives of the agencies concerned. These detailed reports, including budgetary data, are in the files of the Committee and a summary description of the program of each agency is included as a part of the full report of this Committee. The annual cost in state tax funds for these medical and health services is approximately $30,000,000. Local and federal tax funds still further increase this total. Furthermore, expenditures for medical care for those receiving public assistance, with major support from federal sources, has been increasing and there is no indication of a reversal of this trend.

The Committee had particular concern with the provision of medical services at public expense. In addition to the state hospitals for tuberculosis and mental illnesses, six state agencies contract for medical care. There was wide diversity, rather than general uniformity, in plans. There was a greater variation in determining eligibility than deemed desirable. There was no uniform policy governing the selection and payment of medical consultants and hospitals. The more adequate investigation of the financial status of the family of patients in state hospitals is needed.

The Committee was further concerned by the lack of definition of the role of welfare agencies in medical and health matters. The responsibility and authority of the Public Welfare and Public Health agencies for medical and health matters is not now adequately specified. The Committee holds that services provided by the medical professions, particularly for medical care in and out of hospitals, should be the responsibility of the medically directed health organizations. As a basis for sound planning and to foster even better working relationships, a clear definition of roles in medical matters is indicated.

In the matter of tuberculosis control the state at present is believed to have infectious cases which would more than completely fill all available beds in the tuberculosis hospitals. However, there are currently vacant beds. Moreover, in the State Prison in Raiford, with present hospital facilities admittedly inadequate, open cases of tuberculosis are being cared for under less than satisfactory conditions. Particularly vigorous case-finding and follow-up programs at this time are indicated to maintain the progressive decline of this disease and through prevention to avoid the high future cost of treating this prolonged disease.

The continuing inadequacy of physical facilities, despite current expansion, is the notable feature in the mental hospitals, child training schools and the State Prison System. There is the lack of any special facility for the care of psychotic children.

The Alcoholic Rehabilitation Program is a pilot activity rather than one designed to fully resolve a statewide problem. Eventually other agencies will need to participate in the application of effective procedures. The present program appears to be arriving at a point where appropriate agencies—on a cooperative pilot basis—might with advantage be encouraged to incorporate specific portions of the alcoholic rehabilitation program within their broader activities.

Regarding organization of medical and health services in Florida the Committee sees no serious disadvantage in distributing the responsibilities for medical and health services at the state level to the agencies now concerned. However, at the community level consolidation is essential for economical and efficient operation. The state has virtually complete coverage by well established county health departments which could be strengthened so they could provide broader services.

In view of the importance of accidents as the first cause of death in Florida for persons from one to 45 years of age, the accident prevention programs of state agencies were examined separately. There is much concern with work in this field but at present each agency is proceeding independently with its own particular activities. That the programs are not as effective as desired is apparent from mortality and morbidity statistics.

The Committee is favorably impressed with the variety and amount of needed medical and health services provided through official agencies to the people of Florida. They commend the agencies for the generally smooth and effective cooperative relationships. There is no significant amount of unwarranted overlapping or duplication of services at state level. With a program distributed through 13 agencies there could be obvious imbalance, but this was not evident. Despite these generally favorable observations, it also was clear that there are possibilities for improvements in organization and in operations. The following recommendations call attention to these and are designed to still further strengthen these very creditable medical and health services.

Recommendations

10. For the provision of medical care at public expense: central purchasing by the State Board of Health of medical care vendor services together with establishment of uniform criteria for eligibility for medical services at public expense and the adoption of a uniform policy governing the selection and payment of medical consultants and hospitals.

11. For the provision of medical services to recipients of public welfare: the assignment of responsibility for medical and health matters to the medically directed health agency with the evolution of appropriate interagency administrative relationships.

12. For tuberculosis control: an intensification of case-finding activities to identify and treat every active case of tuberculosis at the earliest possible stage of the disease, and for the best use of tuberculosis hospitals a consideration of the practicability of transferring prisoners with tuberculosis to wards with appropriate security in a tuberculosis hospital.

13. For better care in state institutions: proceed without delay with the planned and needed expansion of mental hospitals, child training institutions and the medical facilities in the State Prison System and establish a unit for the treatment of psychotic children.

14. For improvement of the alcoholic rehabilitation program: the cooperative development by the Alcoholic Rehabilitation Program, and some selected local health department, of a pilot control program incorporated within the general community health program.

15. For the organization of medical and health services: no wider dispersion of responsibilities at state level, and at the community level an immediate effort to consolidate all medical and health programs for the protection and promotion of health, physical and mental, within strengthened and expanded health departments which would serve the local needs of the various state agencies on a cooperative basis.

16. For school health services: continue and strengthen the present cooperation program.

17. For accident prevention: the designation of a Governor's interagency Committee on Accident Prevention to foster and coordinate all promising activities.

18. For the promotion of interagency cooperation in medical and health programs: the establishment of an interagency advisory committee or council to consider on a continuing basis interrelated medical and health services and facilities with a view to their progressive improvement.

Role of Voluntary Health Agencies in Florida

There has been a marked expansion of voluntary health agencies in the past decade. Prior to 1949 only five are known to have been active in Florida. Since that time state organizations of voluntary health agencies, with full time paid staff, have been established in Florida at a rate of more than one per year. Of 19 known agencies, 18 provided data concerning activities and budgets. (Only the National Foundation failed to submit the information requested.) Detailed reports on the activities of each of these agencies are in the files of the Committee, and brief summary statements are a part of the full report.

The people of Florida contribute voluntarily each year nearly 5 million dollars for the support of these 18 agencies, and with the estimated contributions to the National Foundation, the total would be between 5.5 and 6 million dollars, an amount equal to the total tax funds provided for any major statewide health program. Each voluntary health agency has tended to develop a distinctive and independent program. Some

emphasize research, others education and promotion. Provision of direct medical service is unusual. Cooperative programs with official agencies are common, but there is little coordination of activities among the voluntary health agencies themselves.

The important contribution of voluntary health agencies in the initiation and promotion of health activities in Florida is warmly acknowledged by the Committee. Likewise, the generosity of the residents of Florida in voluntarily making available these millions of dollars for special health activities is recognized. The work of the leaders who give of their time, with and without compensation, displays an admirable concern for the welfare of the less fortunate. Even though present activities are commendable, it is believed they may be strengthened. It is feared also that there may be danger to the voluntary health agencies through wholly uncontrolled multiplication of organizations seeking public support and particularly through the possible promotion of agencies with less worthy programs.

Funds provided voluntarily by large numbers of contributors for the support of the voluntary health agencies are regarded as the public's money. The public cannot see and appraise the results derived from the expenditure of their funds for widely dispersed health activities. Inevitably there is a degree of public uncertainty as to whether funds contributed are used to the very best advantage. Therefore, it is recommended:

19. For the protection of the public's investment and of the favorable reputation of the agencies: legislation requiring the issuance of permits by an appropriate official agency (aided by the guidance of an advisory board) for the solicitation of funds for voluntary health activities, with provision for public reporting of activities and budgets.

20. For more effective coordination of the work of voluntary health organizations: every encouragement to be given to evolve a State Coordinating Council to facilitate interchange, to promote effective evaluation, to coordinate activities and to plan cooperatively with related professional bodies and official agencies.

Maximum Utilization of Health Personnel

Currently 7,037 physicians hold licenses to practice in Florida and of these 4,585 are residents of the State. There are also 519 licensed osteopaths, 2,356 dentists, 14,443 registered nurses and 6,059 licensed practical nurses. Sound scholarship plans assure opportunities for training in the major health professions to the sons and daughters of Floridians. In this State, as in most states, the troublesome problem is one of distribution of medically trained personnel. Placement services are maintained by some institutions and professional bodies. However, there is no central body with general responsibility for maintaining current data as to needs and personnel available. Therefore it is recommended:

21. For distribution and placement of medically trained and health-related persons to satisfy needs: that the State Board of Health maintain a central "clearing house" for placement services with the major objective of bringing together interested prospective employees and employers, and of accumulating and distributing information concerning openings for qualified persons who are interested in locating or relocating in Florida.

Radiological Health

A statement of this problem was presented by the radiologist member of the Committee and is a part of the full report. There is the problem of assuring a safe and effective use of radium and radioisotopes and of x-ray particularly as widely employed for diagnostic purposes. Education of the public and the medical profession is involved and special control measures need to be evolved. Therefore, it is recommended:

22. For the better control of the medical application of ionizing radiation: that there be designated a medical committee on radiological safety, a majority of whose members would be qualified radiologists, to serve as a subcommittee of the Radiological Safety Committee of the Florida Nuclear Development Commission.

Implementation

The Committee recognizes that the improvements visualized in its recommendations may be attained through different channels. Recommendation number 7 seeks a modification of federal legislation and outlook. State legislative authorization would be required to implement recommendations numbers 3, 6 and 11, relating to the provision of nursing home and hospital care for the recipients of public welfare with partial support through federal matching funds, including administration of such programs, and number 19 requiring permits for voluntary health agencies. Three recommendations, numbers 5, 12 and 13, involve state budgetary considerations. Others

might be attained by administrative directive or suggestion, e.g., the last part of number 3 and numbers 9, 10, 17, 18, 21 and 22. Professional persuasion and interagency planning are the major needs for implementation of the remainder (Nos. 1, 2, 4, 8, 14, 15, 16 and 20.) For all, the support of the professional groups involved and an informed public is to be desired. Therefore, it is recommended:

23. For the dissemination of factual data relating to medical and health services in Florida: that the Committee be authorized to prepare for appropriate publication selected findings of importance to the medical profession, hospital administrators, health workers and the public.

State Health Board Names New Buildings For Distinguished Florida Physicians

With appropriate ceremonies, the Florida State Board of Health on Feb. 10, 1959, named its new buildings for two former state health officers, Dr. Henry Hanson and Dr. Joseph Yates Porter, who were great benefactors of Florida and distinguished members of the Florida Medical Association. At the first ceremony at 2 p.m., the $600,000 central laboratory building, dedicated in 1954, was named the "Henry Hanson Building" in honor of a Florida physician who won international renown in the field of control of tropical diseases. The second ceremony, which followed immediately, marked the dedication and the naming of the recently completed half million dollar administration building as the "J. Y. Porter Building," honoring Florida's first State Health Officer.

Dr. Charles J. Collins of Orlando, President of the State Board of Health, officially welcomed the gathering at the first ceremony and presided over the unveiling of the name. Dr. Wilson T. Sowder of Jacksonville, State Health Officer, introduced the special guests. In a biographical sketch presented by Dr. T. Z. Cason of Jacksonville, the remarkable accomplishments of Dr. Hanson during his brilliant career were reviewed. For 16 years he served the people of Florida, and his work contributed significantly to the subsequent rapid development of the state. As Director of the Division of Bacteriological Laboratories of the State Board of Health from 1909 through 1916, he established district laboratories in Tampa and Pensacola and developed the state laboratory program into a highly effective means of controlling communicable diseases. He twice served as State Health Officer, from 1929 until 1935 and again from 1942 until 1945, proving himself an able and courageous administrator as well as a profound student. He was a founder and the first president of the Florida Public Health Association.

Dr. Hanson became an international authority on tropical diseases, especially malaria and yellow fever. For approximately 16 years, before and between his two terms as State Health Officer, he served as an adviser in public health and tropical diseases to the governments of Central America and South America, much of his work being accomplished in Peru, Columbia, San Salvador and Venezuela. He was affiliated with the Rockefeller Foundation, the Pan American Sanitary Bureau, the United States Public Health Service and the West Africa Yellow Fever Commission. For his outstanding work he was decorated by the governments of Peru, Paraguay, Ecuador and Cuba.

Born in South Dakota, Dr. Hanson became a resident of Florida early in his career and made his home in Jacksonville. He died in 1954 at the age of 77.

At the second ceremony, Dr. Sowder made the introductions and Dr. Collins conducted the dedication of the administration building and the unveiling of the name. The biography of Dr. Porter was presented by his grandson, J. Y. Porter IV, a Key West attorney. A native Floridian, Dr. Porter was born in Key West in 1847. In 1886, he served as the twelfth president of the Florida Medical Association and also served twice as secretary. When Gov. Francis P. Fleming called a special legislative session in 1889 to create the Florida State Board of Health, Dr. Porter, appointed to head the new agency, became Florida's first State Health Officer. He had previously become an authority on epidemic diseases during 19 years of service as a medical officer of the United States Army and was well prepared for a public health career. He had received national attention for his handling of yellow fever epidemics in Monroe County in 1887 and in Jacksonville in 1888.

For 28 years Dr. Porter served Florida as State Health Officer, relinquishing the office in 1917. He was a pioneer in public health far in advance of his times. An excellent public administrator and a man of unusual wisdom and understanding, he stressed public health education, recommended mental health training as a prereq-

uisite for teachers, sought the establishment of isolation centers for tuberculous patients, organized Florida's first antimosquito association, and demonstrated for the first time in the United States the mosquito as a yellow fever carrier. He emphasized the importance of safe water supplies and adequate sewage disposal systems, developed programs for the control of hookworm, fought hard for compulsory vaccination and recommended a program for the aid of crippled children. Some of the basic problems this nationally recognized public health authority clearly outlined and advocated over half a century ago are only now being accomplished. Dr. Porter died in 1927 at the age of 79.

At the conclusion of the ceremonies, guests were invited to inspect the two buildings. Guided tours were conducted from the lobby of each building, and many availed themselves of the opportunity to view the greatly needed new quarters.

Seminar in Internal Medicine
College of Medicine
University of Florida
March 19-21, 1959

Beginning on March 19, a two and a half day conference on some of the hematologic and respiratory disorders commonly encountered in clinical medicine will be held at the College of Medicine of the University of Florida in Gainesville. One day will be devoted to hematologic problems, and among the topics to be considered are: pitfalls in the management of anemia; newer viewpoints on transfusion of blood and its components; abnormal hemoglobins and their role in disease; multiple myeloma; and recent advances in the management of leukemic patients. On the second day of the Seminar there will be a consideration of newer concepts of the pathogenesis of emphysema; aberrations in the mechanics of respiration caused by various diseases; technics of value in improving ventilatory function; functional and anatomic changes in the lungs following pneumonia; and problems in pulmonary gas exchange. The program will be concluded with a presentation of patients demonstrating various problems in these areas, and a clinicopathologic conference.

The registration fee for this Seminar is $25. There will be no charge for hospital interns or residents who wish to attend.

Speakers on the program are: Dr. Lawrence E. Young, Professor of Medicine, University of Rochester School of Medicine and Dentistry; Dr. Ralph L. Engle Jr., Associate Professor of Medicine, Cornell University Medical College; Dr. Kenneth McLean, Research Associate, Mayo Clinic; Dr. Donald L. Fry, National Heart Institute; and the following members of the faculty of the College of Medicine: Dr. Arthur B. Otis, Professor of Physiology; Dr. William W. Stead, Associate Professor of Medicine; and Dr. W. Jape Taylor, Assistant Professor of Medicine.

This is the second annual Seminar devoted to selected topics in internal medicine. The program has been designed so as to be of interest to all physicians, and the material to be presented will have direct application to the understanding and management of clinical problems.

For further information write to Dr. William C. Thomas Jr., Director, Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

A.M.A. Journal Issues Special Edition On Medical Care Plans Report

Every member of the Florida Medical Association would do well to read carefully the special edition of The Journal of the American Medical Association, issued on Jan. 17, 1959, which presents the Report of the Commission on Medical Care Plans of the American Medical Association. This volume, Part I of the final report, contains the reports of the various committees as adopted by the 15 member Commission and also the conclusions and recommendations reached. Part II, issued separately, contains the statistical data and background materials. Thus the material for review and study is presented as compactly and concisely as possible so that the reader may secure the benefit of the Commission's deliberations and then proceed to greater detail if he so desires.

The report is the culmination of a three and one-half year study of the various types of medical care plans throughout the United States. The purpose of the study was to determine whether current medical care plans are effectively promoting the highest quality of health services, the welfare of the public and the medical profession, and the ethical standards of the medical profession.

The report is therefore the product of numerous interviews, field studies, and conferences with representatives of local and state medical societies, individual physicians and others.

The study is devoted basically to an examination of those voluntary medical care plans and programs, other than hospitalization plans, through which persons receive the services of physicians for surgical and medical care. Prepayment plans represent the majority of those studied. In order to permit the examination of certain characteristics and problems as they affect the relationships between patient and physician, patient and plan, and physician and plan, other types of plans are also reviewed. These include student health programs and occupational health programs, including nonoccupational medical care programs in industry and workmen's compensation.

The Commission has endeavored to deal primarily with those elements and issues which, over the years, have appeared to be matters of particular interest and concern to the medical profession and which have tended to create a divergence of opinion regarding various aspects of medical care provided by or through these programs. This excellent report, for which the Commission deserves the highest commendation, affords every physician the opportunity to familiarize himself thoroughly with the various aspects of the individual plans. Thus informed, he is in a position to evaluate with an open mind this important problem in the light of current thinking and experience.

In his monthly message in this issue of The Journal, President Annis stressed the importance of this type of approach to the pressing medical problems of today. Every member of the Association is urged to examine carefully and objectively, with the aid of this report, the merits and demerits of all proposed plans for providing medical coverage.

Hotel Reservations For Association's Meeting

Hotel reservations for physicians attending the Eighty-Fifth Annual Meeting of the Florida Medical Association, May 2-6 should be made directly with the hotel. The Americana Hotel is headquarters for the meeting. Physicians desiring to stay in this hotel should send their reservations to Americana Hotel, Bal Harbour, Florida.

Twelfth Clinical Meeting American Medical Association Report of Delegates

Addressing the House of Delegates at the opening session of the American Medical Association's Twelfth Clinical Meeting, held in Minneapolis on December 2 to 5, 1958, Dr. Gunnar Gundersen of La Crosse, Wis., President of the American Medical Association, called upon the medical profession to exert leadership and imagination in meeting the problems of these changing times. He urged practical actions to solve medicoeconomic challenges, declaring that "the time has passed for policies based on generalities, platitudes and flag-waving." He also urged support of proposals for an International Medical Year.

Responding to Dr. Gundersen's call for action, the House gave consideration to a wide variety of issues. Among them were health care of the aged, the report of the A.M.A. Commission on Medical Care Plans, osteopathy, expansion of medical education facilities, the Association's administrative changes, the report of the Committee to Study A.M.A. Objectives and Basic Programs, and voluntary health organization fund raising.

HEALTH CARE OF THE AGED.—With regard to the health care needs of the aged, the House of Delegates adopted the following proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees:

"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

"Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicans everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will

permit the development of such insurance and prepayment plans at a reduced premium rate."

In order to effect the immediate implementation of such a program, the House directed that copies of the proposal be distributed to medical society approved plans, including Blue Shield and private insurance programs, requesting their cooperation.

Report of Commission on Medical Care Plans.—Deferring action until the June 1959 meeting, the House invited constituent associations to review the report of the Commission on Medical Care Plans in the interim and arrive at decisions in regard to the following basic points:

"1. Free Choice of Physician.—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. Closed Panel Systems.—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

It was recommended that the constituent associations send their replies to the Executive Vice President 60 days in advance of the June 1959 meeting.

Osteopathy.—A resolution which would have recognized that constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states was not deemed the appropriate solution to the osteopathic problem. Instead, the House requested the Judicial Council to review past pronouncements of the House on osteopathy and the status of the laws of the various states in this regard, and to present its report and recommendations at the June 1959 meeting. The House "noted with favor that the American Osteopathic Association has amended its objectives as stated in its constitution by deleting reference to the cultism of Andrew J. Still."

Medical Education.—Approval was given to a statement by the Council on Medical Education and Hospitals supporting the development of additional facilities for basic medical education, and the House urged the entire profession to give that policy strong support in order to correct misinterpretations of the Association's viewpoint regarding the supply of physicians. The statement suggested that existing medical schools should consider the possibility of increasing their enrollments and developing new facilities and declared that American medicine has the responsibility to encourage the creation of new four year medical schools and two year basic science programs by institutions of higher learning which can provide the desirable setting.

A.M.A. Administrative Structure. — The House approved a Board of Trustees report announcing reorganization of the Chicago staff into seven divisions: Business, Law, Communications, Field, Scientific Publications, Socio-Economic Activities, and Scientific Activities. The Board also reported that the Committee on Legislation has been renamed the Council on Legislative Activities, with the Director of the Law Division as Council secretary. This new Council will undertake an enlarged, strengthened legislative program, closely coordinated with the activities of the new field staff and the Washington Office. The latter has also been reorganized, with over-all direction coming from Chicago.

A.M.A. Objectives and Basic Programs.—Commending the report of the Committee to Study A.M.A. Objectives and Basic Programs, the House declared that it may be a significant milepost in the Association's history. One recommendation was a suggested amendment of Article II of the Constitution: "The objectives of the Association are to promote the science and art of medicine and the betterment of public health and an understanding of the socio-economic conditions which will facilitate the attainment of these objectives." Approval was also given to a recommendation that the Board of Trustees give serious consideration to opening the publications of the Association to a free and open discussion of socioeconomic problems applicable to medicine.

In addition, the House recommended that the Board of Trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. "In the scientific fields," the House declared, "the role of the A.M.A. should be primarily that of leadership, but every endeavor should be made to bring about coordination of the special fields of scien-

tific interest of the other national medical organizations."

FUND RAISING.—Since in some quarters the action taken last June at San Francisco was interpreted to mean disapproval of inclusion of voluntary health agencies in United Fund drives, the House passed a resolution stating that "the American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives." The resolution also requested the Board of Trustees to arrange a conference at the highest level with the voluntary health agencies, the United Funds and other groups interested in the raising of funds for health causes, with a view to resolving misinterpretations and other difficulties in this area.

MEDICARE PROGRAM.—Taking cognizance of the recent restrictive changes in the Medicare program, the House expressed regret at the substitution of federal facilities for private care in the areas mentioned. It urged the Association to encourage the reestablishment of services under the free choice principle to accomplish the original intent of the act.

SOCIAL SECURITY ACT.—The delegates recommended that the Social Security Act be amended by the Congress to permit states to combine the present four Public Assistance medical programs into a single medical program administered by a single agency and making available uniformity of services to all eligible Public Assistance recipients in the state.

MISCELLANEOUS ACTIONS.—The House gave hearty approval to the purpose, content and format of The A.M.A. News and recommended continuance of the publication under its present and established policies. It authorized the Council on Medical Services to sponsor at the earliest practicable date a Congress on Prepaid Health Insurance and approved a plan to develop "Buyers' Guides" which will be sent to physicians to help their patients analyze the merits of available health insurance programs. The delegates encouraged the voluntary registration of the paramedical personnel who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time. They agreed with the Committee on Medical Practices that relative value studies should be conducted by each constituent medical association but not on a national or regional basis by the American Medical Association. They also urged each constituent society to establish a committee on rehabilitation to carry out activities recommended by the Board of Trustees, called for continued activity at all levels to stimulate the development of effective poliomyelitis inoculation programs and suggested that the Association take immediate steps toward developing a plan whereby reserve medical units and individuals not immediately involved in military operations could be used to supplement civil defense operations.

GENERAL PRACTITIONER OF THE YEAR.—Dr. Lonnie A. Coffin of Farmington, Iowa, became the first Iowan to receive the annual GP award. He was named the 1958 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Coffin accepted his gold medal on behalf of "all the men who have dedicated their lives to the general practice of medicine."

AMERICAN MEDICAL EDUCATION FOUNDATION.—At the opening session, gifts to the American Medical Education Foundation from six state medical societies were announced: California, $150,305.75; Indiana, $35,110; New Jersey, $25,000; New York, $19,608; Utah, $9,977.50, and Arizona, $8,657.50. To this total of almost $250,000 the American Medical Association added a contribution of $100,000 to the Foundation.

ATTENDANCE.—The total registration at the meeting was 6,025. Of this number, 2,658 were physicians.

Respectfully submitted,

Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Cardiovascular Seminar Scheduled For April 3-4 at St. Petersburg

The annual Suncoast and Hillsborough County Cardiovascular Seminar will be held April 3-4 at the Tides Hotel and Bath Club, Redington Beach, St. Petersburg. Seven specialists in various phases of diagnosis, treatment and surgery in the cardiovascular field will present papers and take part in panel discussions on the program beginning at 10 a.m. each day.

Among those appearing on the program are Dr. J. Willis Hurst, Professor of Medicine, Emory University, whose subjects will be "Some-

thing Old—Bedside Observations and Heart Disease," and "Something New—Current Cardiovascular Research;" Dr. John Hickam, Professor of Medicine, University of Indiana, who will present papers on "Management of Cor Pulmonale" and "Treatment of Carbon Dioxide Narcosis;" Dr. H. M. Keith, Assistant Professor of Pediatrics, University of Toronto Medical School, Chief of Cardiology Service, Sick Children's Hospital, who will speak on "Congenital Heart Disease" and Dr. Herbert Warden, Assistant Professor of Surgery at the University of Minnesota.

Credit for attending the Seminar will be given by the American Academy of General Practice. The registration fee is $5.00.

OTHERS ARE SAYING

How Can You Prevent A Suit?

We, in Florida, are in the unhappy circumstance wherein there is an alarming increase in number and size of malpractice suits against hapless physicians. We are concerned about the rapidly rising costs of malpractice insurance, especially since the increase is greater in Florida than in any other state in the union. We are concerned because of a general tendency for juries to award larger and larger settlements in malpractice and disability suits regardless of the circumstances and frequently with utter disregard of the testimony of expert witnesses. In plain fact, doctors are, at times, victims of a virtual "shake down" racket which is not only instigated, but condoned by members of the legal and, at times, medical profession. Is this trend to continue and if so what can be done to combat it?

It has been recommended by aroused medical groups in other areas that physicians set up their own malpractice insurance company in order to offer the insurance at a lower rate and at the same time reduce unjust criticism of each other. One of the fundamental factors in any malpractice suit is condemning evidence submitted by a physician, nurse or hospital administrator, usually innocently but damaging in the formulation of malpractice litigation against a member of the medical profession. However, the insurance business is a highly competitive field and we have already experienced certain difficulties in establishing our own program. In addition, if we are opposed to other socio-economic proposals we can hardly justify an attempt to socialize the insurance industry even on a local medical basis.

A more practical plan which is not only feasible but is in successful operation in some counties of the nation is a joint medical-legal reviewing committee. This commitee, with the cooperation of both professions, reviews all malpractice claims against physicians and decides on the merits of the case before it can be brought before the court. By this action the so-called nuisance cases may be excluded from the court calendar and only legitimate claims may proceed for legal settlement. The presence of this committee will discourage many would-be accusers who hope to reap a profit from a physicians' insurance company. This will also serve to reduce the early settlements by physicians who, although probably guiltless, fear the bad publicity associated with a malpractice suit. If active, determined committees such as these were established in major counties of this state a potent force could be maintained over this spreading evil. We have seen the very effective measures taken by the grievance committees in our societies. Picture this group being enlarged into a major grievance committee attended by lawyers and doctors alike, to act not only as a fact finding body but as a respected group of individuals who could render a decision, the gravity of which could not be denied. "To check the trend toward higher and higher malpractice verdicts, doctors need to change their tactics," claims Edwin J. Hoffman of the AMA law department. "Medicine is not doing enough to improve the climate in which claims are presently being considered."

A large step in this direction has recently been made by the AMA. Approved by the House of Delegates of both the AMA and the American Bar Association is a new code of interrelationship which is a set of suggested rules of conduct for both professions. It is constructed on general terms in order to adapt it to local conditions. This is the device we need to expand existing medico-legal relationship into workable, effective committees on a county and state level that will return this suit insanity to reasonable grounds.

A program established by the American College of Surgeons two years ago has been effective in forestalling malpractice suits. By securing all the insurance from one underwriter a vigorous prevention plan is exerted and only one case reached trial early this year. It has also been suggested that malpractice cases should be taken from the courts and placed in the hands of a

commission comparable to a workmens compensation commission. This group could then decide what award, if any, should be given a patient.

It is high time that physicians take concerted action now to establish some effective measures while we still retain some control over our practices. Every one of us as a citizen has a duty to bring our concept of justice back to reality.

Miles W. Thomley, M.D.
The Bulletin
Orange County Medical Society
Oct., Nov., Dec., 1958

BLUE SHIELD

Blue Shield Informational Meeting Held

On December 13, 1958, an Informational Meeting of the Active Members of Blue Shield was held at the Blue Cross-Blue Shield Building in Jacksonville. Fifty-seven doctors from the active membership of Florida Blue Shield, which includes the seated House of Delegates of the Florida Medical Association, met in an afternoon and evening session to hear presentations about Blue Shield and Commercial Insurance.

By resolution of the Florida Medical Association, and in reply to questionnaires, it was the purpose of this meeting to inform the profession better on Blue Shield as well as Commercial Health Insurance.

The program, arranged by the Blue Shield Board of Directors, was as follows:

Afternoon Session

What is Blue Shield?	Russell B. Carson, M.D., President, Blue Shield of Florida, Inc.
Role of the Individual Doctor in Making Blue Shield Work	Henry J. Babers Jr., M.D., Chairman, F.M.A. Advisory Committee to Blue Shield
Trends in Florida's Blue Shield	H. A. Schroder, Executive Director, Blue Shield of Florida, Inc.
Commercial Insurance Company Types of Coverage	John A. Wilhelm, M.D., Medical Director, Gulf Life Insurance Company
Program of the F.M.A. Committee on Commerical Health Insurance	Duncan McEwan, M.D., Chairman F.M.A. Committee on Commercial Health Insurance
Blue Shield Claims Committee Problems	Samuel M. Day, M.D., Medical Consultant for Blue Shield of Florida, Inc.
Dinner Served in Blue Shield-Blue Cross Building	

Evening Session

The Importance of a Strong National Blue Shield (Dr. Stubbs is a practicing physician in Washington, D.C., and is spokesman for Blue Shield before Congress)	Donald Stubbs, M.D., Chairman, Board of Directors, Blue Shield Medical Care Plans (The National Blue Shield Organization)

(Continued on page 1056)



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Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

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Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn—". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

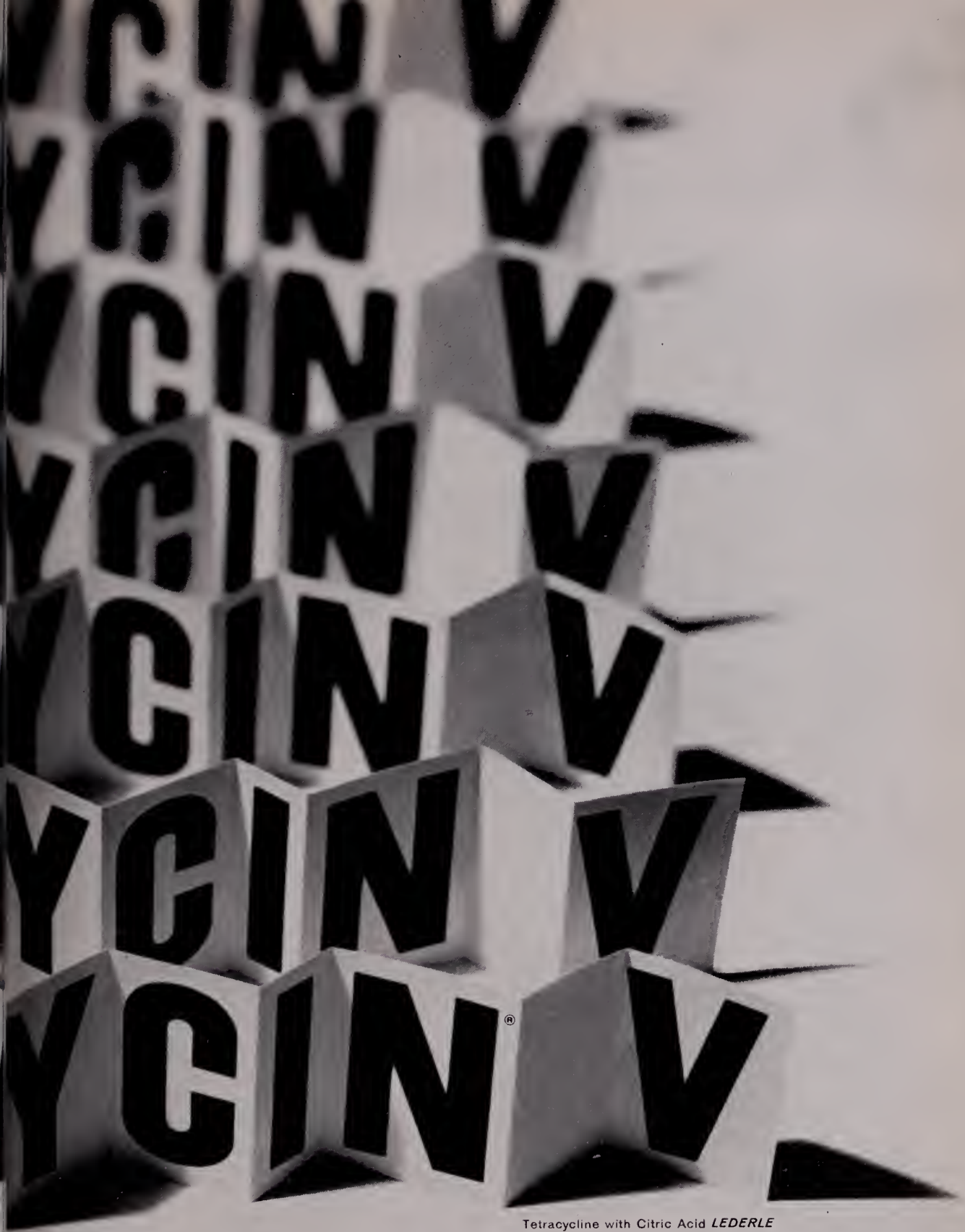
The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg., ampuls of 25 mg. (1 cc.) and Nilevar Drops of 0.25 mg. per drop.

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(Continued from page 1052)

A summary of the talks of the first three speakers is contained in this article, and the other addresses made at the meeting are scheduled for publication in subsequent issues of The Journal.

What Is Blue Shield?

RUSSELL B. CARSON, M.D.
PRESIDENT OF BLUE SHIELD OF FLORIDA, INC.
FORT LAUDERDALE

Blue Shield today is a vigorous and progressive economic arm of the medical profession. It is an acknowledged leader in its field reflecting the foresight of the profession in meeting a public need with the guidance of that profession. Blue Shield stands alone it its field because of medical guidance and judgment in its operation and organization; therefore it is not a third party.

Your Blue Shield today is preparing to meet the future. It is more than ever necessary for Blue Shield to have a close working relationship with each participating physician and the best liaison with every medical society. We must make Blue Shield truly a doctor-sponsored Plan.

Mobility and expansion of industry and labor, as well as governmental interest in health care, have necessitated the development of a strong national organization of Blue Shield Plans. In this organization, the Blue Shield Medical Care Plans, great stress is placed on the fact that the individual Plans continue to serve the interest of the public and profession locally and cannot cede any power to the national organization which would conflict with the relationship between the local Plan and the local doctors. Adaption to local needs is an extremely important feature of Blue Shield, but a National Association of Plans can present a unified economic medical front on that level.

Operations of the Blue Shield Medical Care Plans include programs and services vital to all aspects of Plan management and operation. These include conferences on enrollment, professional relations, office management and statistical and research programs. These activities are planned to keep Plan personnel well informed and to encourage constructive exchange of ideas towards more effective operation of the individual Plan. In much the same manner as our local Plan, the Blue Shield Medical Care Plans has a Board of Directors elected by the Plan and a majority of its members are doctors of medicine.

How far can Blue Shield go? How far should it go? A new frontier is taking shape, especially right now. Our industrial and economic horizons

POST GRADUATE SEMINAR
DEPARTMENT OF SURGERY
UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

April 30 and May 1, 1959
Second Floor—Central Building
Jackson Memorial Hospital—Miami 36, Florida

PROGRAM

April 30, 1959

9:00 a.m. Welcome and Opening Remarks: Jay F. W. Pearson, Ph.D., President, University of Miami
9:30 a.m. Selection of Patients for Mitral Commissurotomy with Discussion of Results: Robert S. Litwak, M.D.
10:20 a.m. Management of Acute Head Injuries: David Reynolds, M.D.
11:15 a.m. Current Status of Tonsil and Adenoid Surgery: J. Ryan Chandler, M.D.
12:15 p.m. Lunch
1:30 p.m. The Treatment of Colles Fractures: Wallace Miller, M.D.
2:10 p.m. Indications for Surgery in Peptic Ulcer: Frank T. Kurzweg, M.D.
3:15 p.m. Ward Rounds

May 1, 1959

8:00 a.m. Fluid and Electrolyte Balance: Its Clinical Application: John J. Farrell, M.D.
8:50 a.m. Clinical Evaluation of Patients with Arterial Insufficiency: John J. Fomon, M.D.
9:50 a.m. Treatment of Eye Emergencies: Edward R. Norton, M.D.
10:45 a.m. The Use of Adjuvant Chemotherapy for the Treatment of Cancer: Daniel S. Martin, M.D.
11:30 a.m. Selection of Treatment for Patients with Carcinoma of the Prostate: George R. Prout, M.D.
12:30 p.m. Lunch
1:45 p.m. Evaluation of Patients with Low Back Pain: A. Sarmiento, M.D.
2:30 p.m. Detection of Deafness in Children: O. J. Menzel, Ph.D.
3:40 p.m. Laboratory Demonstration:
I. Open Heart Surgery
II. Cancer Chemotherapy

Approved by the Florida Academy of General Practice for 12 hours credit: Category I

Department of Surgery, Post Graduate Seminar
University of Miami School of Medicine
Jackson Memorial Hospital
Miami 36, Florida

Enclosed is my $25.00 registration fee.
Name _____
Address _____
_____ County Medical Society

are continually expanding and will continue to do so at an astonishing rate in the years to come. Although our development will create new opportunities for Blue Shield, our future will not be without problems. Without a doubt, the expanding market will be more discriminating; that is, the Blue Shield program will have to keep pace in change and needs. Blue Shield has attained its success because of the leadership of the profession and the efforts of thousands of doctors determined to see that their Plans serve the needs of the public for a practical method of paying the cost of medical care. The future of the Plan will depend on the kind of support it receives from the medical profession. Blue Shield will go as far as the doctors want it to go. It is as important and successful as the doctors want it to be. The Plan must provide new avenues and opportunities for the doctors to take an active part in shaping the affairs of Blue Shield, and the profession must recognize its prime responsibility in guiding the development of Blue Shield.

Henry J. Babers Jr., M.D.
GAINESVILLE

Today I am not talking as Chairman of the Florida Medical Association Committee of Seventeen, but as an individual. At this time, the Advisory Committee did not have anything particular to offer, but I do want to make the comment that our work has always been a group effort, representing a Committee of the Florida Medical Association whose members have worked wonderfully well together, and I hope have accomplished something good for Florida Medicine.

With regard to the role of the individual doctor in making Blue Shield work, the answer is easy. Let the individual doctor find out as much as possible about Blue Shield. When he does, he will find that with all its faults, Blue Shield is one of our main bulwarks in the defense against the outside control of medicine. He will find that it is certainly a creation of the medical profession to help our patients economically and he will find it is truly under the control of the medical profession. Blue Shield stands for most of the things that we hold fair and correct in our Medical Economics and is one of the few organizations which is under doctor control and prepared to put forth our point of view. When the individual doctor realizes these points, he can put up with any weaknesses and make every effort to remedy them, and with unity of action they can be remedied.



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Let me tell you why it is so difficult at times for the doctor to understand what I have just said. We have reams of things to read, long hours of patient care, and little time to devote to our own Medical Economics. Yet these factors may be the deciding ones in whether we practice good medicine or not. We are caught on the horns of a dilemma, as we must study these things and yet we hardly have the time to do it. The individual doctor must be informed concerning Blue Shield for when he is, as we have seen, he changes from a lethargic or passive person in reference to Blue Shield matters into an active and aggressive booster of the Plan. When a doctor does not know the facts concerning an organization which proposes to represent him, he is naturally suspicious. This attitude applies not only to Blue Shield but to any other organization to which you might belong such as your church or civic club. I think a degree of suspicion is good, but it is important for you to know the facts so that you can make up your mind rationally. At one time, I felt that this was an organization that was trying to tell me what to do, was interfering with my life unnecessarily, but when I found out the truth, I became a real booster. Today we must be informed on the economics of life, especially the economics of medicine, in order to be able to adapt ourselves to present realities.

Communications are important. One of the things that will make a great difference in understanding and communications is the expansion and development of the Professional Relations Department in Blue Shield. Dr. Carson and Mr. Schroder have strongly urged this development, and the Committee of Seventeen of the Florida Medical Association has asked for it. This Department is being developed by men who understand the problems of the doctor and his point of view, as well as the problems of Blue Shield.

The role of the individual doctor in making Blue Shield work is simply a matter of the doctor becoming informed on Blue Shield and taking an active interest in its operation.

H. A. SCHRODER
EXECUTIVE DIRECTOR OF BLUE SHIELD
OF FLORIDA, INC.
JACKSONVILLE

Blue Shield in Florida was started by the medical profession two years after the hospitals of Florida started Blue Cross. These Plans have always been operated as two corporations with separate Boards of Directors, but all of our employees and all of our representatives constantly speak of Blue Cross and Blue Shield as being one in the eyes of the public. Because of this earlier start by Blue Cross, there has always been a difference in the number of subscribers between Blue Cross and Blue Shield; that is, Blue Cross has always had some few thousand more members than Blue Shield. We have constantly striven to close the gap between the two numbers of subscribers. The number of subscribers in each Plan is important to our operation because we divide the operating expenses between the corporations based on this membership. At the present time Blue Cross is paying about 53 per cent of the total operating expenses and Blue Shield is paying approximately 47 per cent of the total. We think that this has been a satisfactory arrangement in dividing the operating expenses.



REID'S

MULVITAB

Each tablet contains:

Vitamin A	8000 USP Units
Vitamin D	800 USP Units
Thiamin HCl	3 mg.
Riboflavin	3 mg.
Pyridoxine HCl	1 mg.
Calcium Pantothenate	5 mg.
Nicotinamide	20 mg.
Cobalamin (Vitamin B-12 Activity)	2 mcg.
Folic Acid	0.25 mg.
Ascarbic Acid	75 mg.
Vitamin E (Alpha Tocapherol Acetate)	2 mg.

REID LABORATORIES, INC. ATLANTA 14, GEORGIA

STOP

running noses and open stuffed noses orally



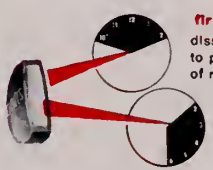
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release Triaminic Juvelets. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: Triaminic Syrup. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Mr. Schroder then charted the progress of Blue Shield and Blue Cross over the past few years and expressed an optimistic view of the future growth of Blue Shield and Blue Cross. He also discussed the problem of rising costs and utilization that affect both Plans. In this regard, he gave some examples of public rate hearings from other states, indicating that this might be a possibility in the case of need for rate increases in Florida. By use of charts, he showed the distribution of Blue Shield funds to doctors in various phases of medical work, and the changing trends in utilization of the Plans.

Mr. Schroder pointed out that the new Blue Shield contract, approved by the House of Delegates in May of 1958, was nearing completion in detail and expressed the hope that by early spring it would be available to the public.

BIRTHS AND MARRIAGES

Births

Dr. and Mrs. Benjamin H. Sullivan of Sarasota announce the birth of a son, Frederic Cashin Sullivan, on Jan. 16, 1959.

Dr. and Mrs. Harold M. Unger of Miami announce the birth of a daughter, Nancy Ann, on Dec. 25, 1958.

Dr. and Mrs. Harold M. Silberman of Coral Gables announce the birth of a son, David, on Dec. 17, 1958.

Dr. and Mrs. Frank G. Long of Jacksonville announce the birth of a daughter, Francine Ann, on Dec. 19, 1958.

Dr. and Mrs. James D. Beeson of Jacksonville announce the birth of a son, Timothy Norman, on Dec. 22, 1958.

Marriages

Dr. Marcia G. Friedman of Coral Gables and Mr. Herbert M. Klein were married on Oct. 26, 1958.

Dr. William M. Madison Jr. of Jacksonville and Miss Julia Cates Carter were married on Dec. 3, 1958.

STATE NEWS ITEMS

A Medical Forum, the first in an intended annual series, is being held at Fort Myers on Monday, Tuesday and Wednesday, March 16-18. The program for the first two days has been planned primarily for the laity. On Wednesday, there will be special sessions for physicians arranged by the Lee-Charlotte-Hendry County Medical Society. At 10:00 a.m. Dr. John Lundy, Chief of the Section of Anesthesiology, Mayo Clinic, will discuss "Means of Controlling Chronic Pain." After a luncheon for physicians, Dr. Frederick Bonte, Head of the Department of Radiology, University of Texas Southwestern Medical School at Dallas, will deliver an address on "Reduction of Patient Dosage in Diagnostic X-Ray Procedures." Several outstanding physicians from Florida also have been invited to participate in the program on Wednesday.

Emory University School of Medicine has announced that the postgraduate course in "Congenital Heart Disease" will be held March 26-28 instead of March 27-29, the dates originally published. The course is scheduled for Grady Memorial Hospital in Atlanta, and the fee is $50. Information may be obtained by writing Postgraduate Education, 69 Butler Street, S.E., Atlanta 3, Ga.

Dr. Lewis A. Shepperd of Miami Beach has returned from five weeks of postgraduate study at the Mt. Sinai Hospital and the Columbia Presbyterian Medical Center in New York City.

(*Continued on page 1072*)



REID'S

3

VITAMIN DROPS

Each cc. contains:

Vitamin A palmitate	4,500 U S P. Units
Vitamin D calciferol	1,000 U S P Units
Ascorbic Acid (C)	75 mg

REID LABORATORIES, INC. ATLANTA 14, GEORGIA

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.

Aluscop

CAPSULES

ANTICHOLINERGIC • ANTISECRETORY • ANTI-ENZYME • ANTACID

with a medical splint

Aluscop capsules, a unique preparation equally as effective as the liquid form, provide rapid and prolonged relief of pain, discomfort and dysfunction in the management of peptic ulcer, hyperacidity, gastro-intestinal spasm or hyperirritability.



Aluscop TREATS THE ENTIRE DYSPEPTIC SYNDROME

- **Methscopolamine nitrate**—the most potent antisecretory agent—35 times that of atropine sulfate, inhibits gastric acid secretion and acts as a "medical splint" through its visceral antispasmodic action.
- **Dihydroxy aluminum aminoacetate and magnesium hydroxide**—two of the most effective antacids—exert dual action without constipating effect.
- **Sodium lauryl sulfate**—a pepsin inactivator—minimizes pepsin erosion and further destruction of tissue to hasten healing of lesions.

Composition: 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

Dosage: 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

Supplied: Bottles of 100 capsules and 12 oz. of suspension.

Lloyd, Dabney & Westerfield, Inc.
Cincinnati, Ohio
Fine Pharmaceuticals Since 1894

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

CM-8043

℞ PRONOUNCED TAY-O

Tao*

(triacetyloleandomycin)

Capsules / Oral Suspension

designed for superior control of common Gram-positive infections

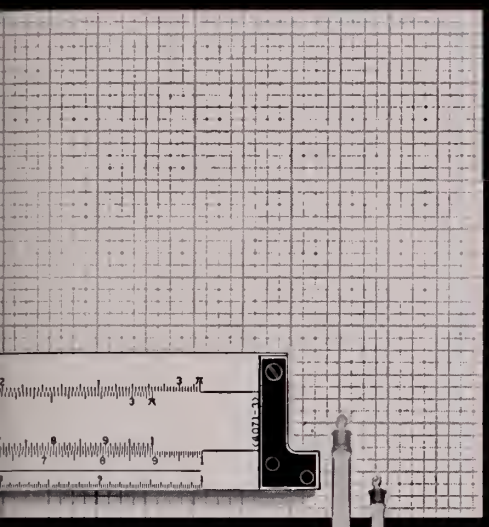


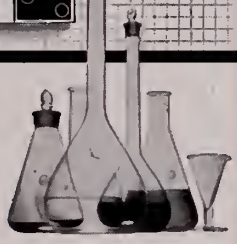


in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failu
ALL INFECTIONS	558	448	80	30
Respiratory infections	258	208	31	19
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	–	6
Otitis media	31	29	2	–
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	230	191	38	1
Infected wounds, incisions and lacerations	41	33	8	–
Abscesses	51	43	8	–
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	–
Pyoderma	19	19	–	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	–
Genitourinary infections	28	19	3	6
Acute pyelitis and cystitis	10	8	2	–
Urethritis with gonorrhea or cystitis	8	8	–	–
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

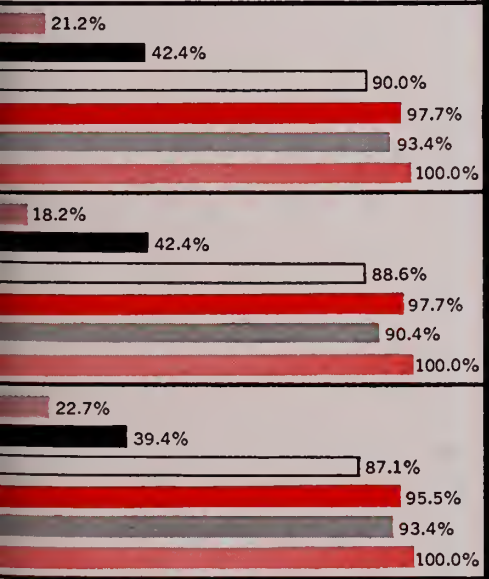




the
oratory:

90% effective
nst resistant staph

RATIVE TESTS BY THREE METHODS
TUBE DILUTION, CYLINDER PLATE)
STAPHYLOCOCCI[9]



ibiotic A 2-10 units — Tao 2-15 mcg.
ibiotic B 5-30 mcg. — Antibiotic D 2-15 mcg.
ibiotic C 5-30 mcg. — Antibiotic E 5-30 mcg.

tage of organisms inhibited by the range of
ıtrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., In press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kapian, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

Tao dosage forms—
for specific clinical situations

Tao Pediatric Drops

For children—flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

Tao-AC (Tao analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

Taomid* (Tao with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

*TRADEMARK

Rx Pfizer

New York 17, N.Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

UNIQUE VITAMIN SUPPLEMENT

NEW VIGRAN CHEWABLES

SQUIBB MULTIPLE VITAMIN SOFT TABLETS

fruit-punch flavored tablets that will actually "melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



can be easily swallowed (small tablet size)

VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth.* Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good.* These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B_1, B_2, niacinamide and C, and significant amounts of other essential vitamins.

Each VIGRAN CHEWABLE tablet contains:

Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C	75 mg.
Vitamin B_1	3 mg.
Vitamin B_2	3 mg.
Vitamin B_6	2 mg.
Niacinamide	25 mg.
Calcium Pantothenate	3 mg.
Vitamin B_{12}	5 mcg.

Available in Rx-size bottles of 30 and 90.

SQUIBB

Squibb Quality—the Priceless Ingredient

'Vigran'® is a Squibb trademark

for the control of all coccal infections



ABBOTT'S ANTIBIOTIC TRIAD

against staph-, strep- and pneumococci



After Millions of Prescriptions An Unparalleled Safety Record

©1959, ABBOTT LABORATORIES 9030

Provides fast, high blood and tissue concentrations—Because Erythrocin Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes—and effective concentrations for at least six hours.

Supported by an unparalleled safety record—During all the years Erythrocin has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad spectrum" action, the normal intestinal flora is virtually unaltered with Erythrocin therapy. And only recently, a well-known investigator said, "Erythromycin is by far the least toxic of the commonly used antibiotics.[1]"

Offers bactericidal action—Unlike broad-spectrum antibiotics, Erythrocin is classed as a bactericidal agent. It offers lethal action against common coccic invaders—resulting in prompt clinical responses.

Provides convenient dosage forms—Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. Erythrocin comes in Filmtabs®(100 and 250 mg.), bottles of 25 and 100. Also, in oral suspension and for intramuscular and intravenous use. Abbott

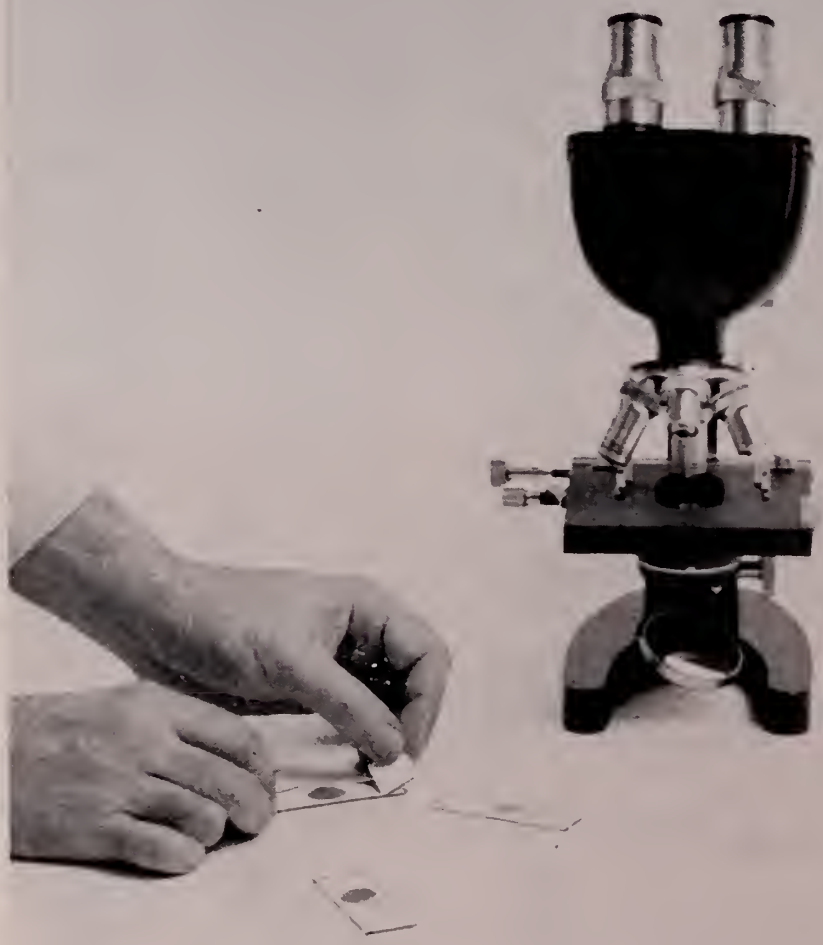
1 Hoeprich, W. E. Hazards of Antibiotic Therapy. J.A.M.A. 168: 875, December 6, 1958
2 Filmtab—film sealed tablets. Abbott pat. applied for

ERYTHROCIN STEARATE

(Erythromycin Stearate, Abbott)

an uncommon antibiotic
for common infections

for those penicillin-sensitive organisms



The Higher Blood Levels of Potassium Penicillin V

COMPOCILLIN-VK Indications—Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. As a prophylaxis in rheumatic fever and in rheumatic heart disease.

COMPOCILLIN-VK Dosage—Depending on the severity of the infection, the usual adult dose is 125 mg. to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

COMPOCILLIN-VK Supplied—In Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. For oral solution, Compocillin-VK comes in 40-cc. and 80-cc. bottles. When reconstituted with water, each appealing (it's a clear red solution) 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

Abbott



against serious and resistant coccal infections



An Important
Lifesaving Antibiotic

903070

The dramatic story of SPONTIN can never really begin to be told.

In little more than a year, this potent antibiotic has compiled an incredible record for saving lives —and often, after all other therapy had failed. Majority of successes involved patients critically ill with staphylococcal infections—conditions that had resisted all other known antibiotic therapy.

Meanwhile, careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

So far, SPONTIN has proved to be a good answer, perhaps the best answer to the resistant staphylococcal problem—and of real value in other serious coccal infections.

Abbott

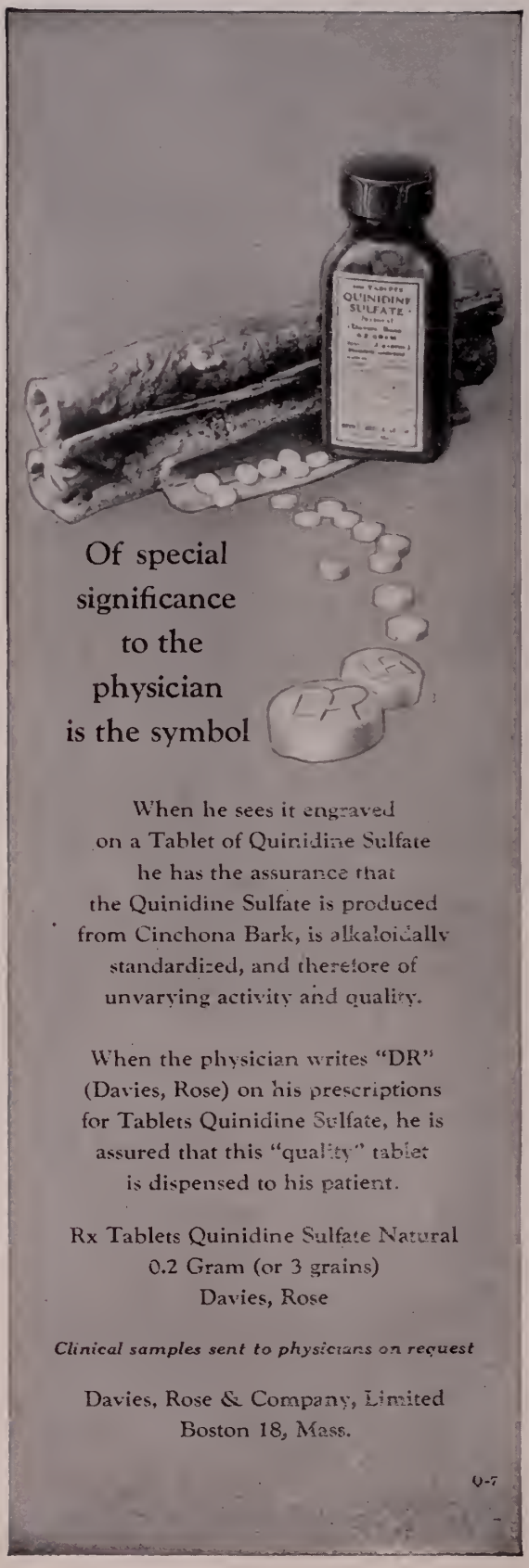
1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct 15, 16, 17, 1958.

Crystallized
SPONTIN®
(Ristocetin, Abbott)

Prepared from pure crystals

Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

Provides Bactericidal Action Against Coccal Infections[1]



(*Continued from page 1060*)

While there he participated in a program in Stapes Mobilization Surgery under the supervision of Dr. Samuel Rosen.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was a participant-at-large on the program of the 55th Annual Congress on Medical Education and Licensure held February 7-10 at the Palmer House in Chicago.

Among Florida physicians participating on the program for the annual meeting of the American College of Obstetricians and Gynecologists being held April 6-8 at Atlantic City will be Dr. E. Frank McCall of Jacksonville, and Drs. James H. Ferguson and J. D. Wargo of Miami. In addition to the presentation of papers by leading obstetricians and gynecologists from all parts of the country, there will be breakfast and clinical conferences, panels, motion picture programs and scientific exhibits.

Dr. Richard T. Smith, Professor of Pediatrics at the College of Medicine, University of Florida, Gainesville, has been selected as one of the ten outstanding young men in the nation by the U. S. Junior Chamber of Commerce. Dr. Smith received an award at the National Awards Conference held recently at Fort Lauderdale.

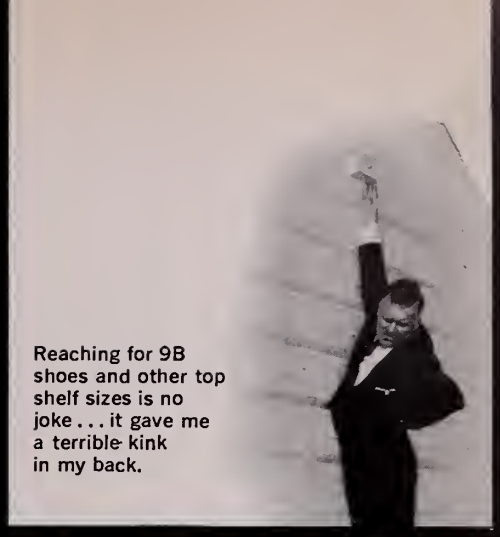
The Fifteenth Congress and Graduate Instructional Course in Allergy of the American College of Allergists is being held March 15-20 at San Francisco in the Mark Hopkins Hotel.

Part II examinations of the American Board of Obstetrics and Gynecology will be conducted at the Edgewater Beach Hotel in Chicago by the entire Board May 8-19. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates, according to Dr. Robert L. Faulkner of Cleveland, secretary of the Board.

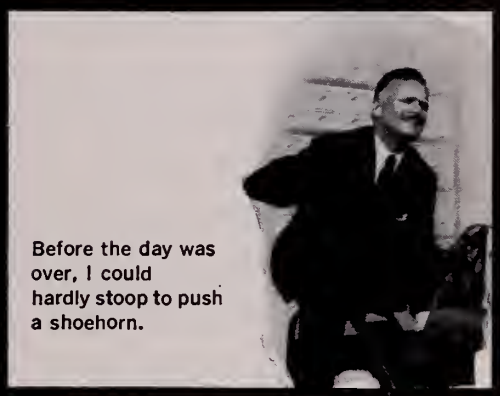
Dr. Thomas S. Edwards of Jacksonville has been elected president of the Duval County Division of the Arthritis and Rheumatism Foundation.

Dr. Louis J. Novak of Hollywood, president of the Heart Association of Broward County, described recent trends in the treatment of ailing

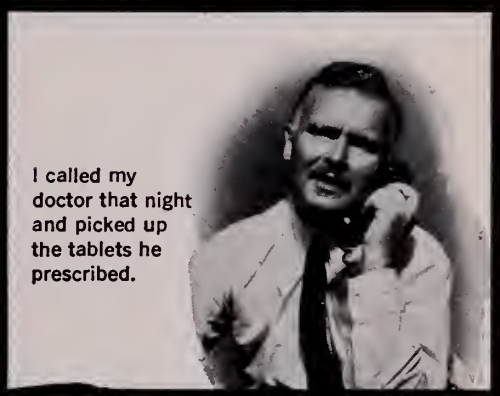
REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



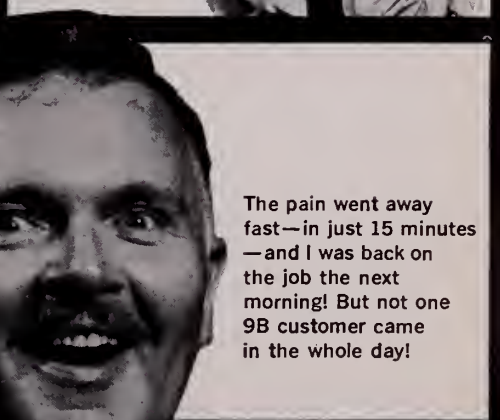
Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.



Before the day was over, I could hardly stoop to push a shoehorn.



I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

Percodan®-Demi & Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

ACTS FASTER — usually within 5-15 minutes. **LASTS LONGER** — usually 6 hours or more. **MORE THOROUGH RELIEF** — permits uninterrupted sleep through the night. **RARELY CONSTIPATES** — excellent for chronic or bedridden patients. **VERSATILE** — new "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

AND THE PAIN WENT AWAY FAST

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,628,185

hearts at a January meeting of the Rotary Club at Hallandale.

Dr. Charles R. Burbacher of Coral Gables has been awarded the Order of the British Empire by Queen Elizabeth for his work with crippled children in the Bahama Islands.

Drs. Geoffrey H. Binneveld of Leesburg, W. Ansell Derrick of Orlando, Thomas E. Langley of Eustis and James A. McLeod of Orlando were among the physicians taking part on the program of the district meeting of the American Cancer Society held the middle of January at Leesburg.

Dr. George H. McSwain of Daytona Beach was principal speaker at the January meeting of the Volusia County Pharmaceutical Association held at Daytona Beach. Dr. McSwain discussed the topic "Cancer Quacks."

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was principal speaker at a recent meeting of the Woman's Club at Oviedo. In his address, Dr. Orr predicted a time of trial in the future for the physician, the farmer and the business man. He stressed the importance of an accurately informed populace and advised the members of the Club to learn how to diagnose what is read.

The Dade County Medical Association committees on local arrangements for the Twenty-Seventh Annual Assembly March 9-12 of the Southeastern Surgical Congress at Miami include: Drs. Walter C. Jones and L. Washington Dowlen, general chairmen; Dr. Edward W. Cullipher, commercial exhibits; Dr. Rudolph E. Drosd, auditorium; Dr. Joseph S. Stewart, reception and registration; Dr. C. Howard McDevitt Jr., entertainment; Dr. Julian A. Rickles, hotel, and Dr. Reuben B. Chrisman Jr., publicity.

Drs. George D. Hopkins II, James L. Bradley, Joseph L. Selden and Newton W. Larkum of Ft. Myers, and Daniel B. Langley of Naples were among the physicians on the program of the district meeting of the American Cancer Society held the middle of January at Ft. Myers.

The 11th Annual Scientific Assembly of the American Academy of General Practice is being

(*Continued on page 1076*)

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Is the most important person with whom we come in contact— in person, by mail or by telephone.

Service Is Our Motto.

CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

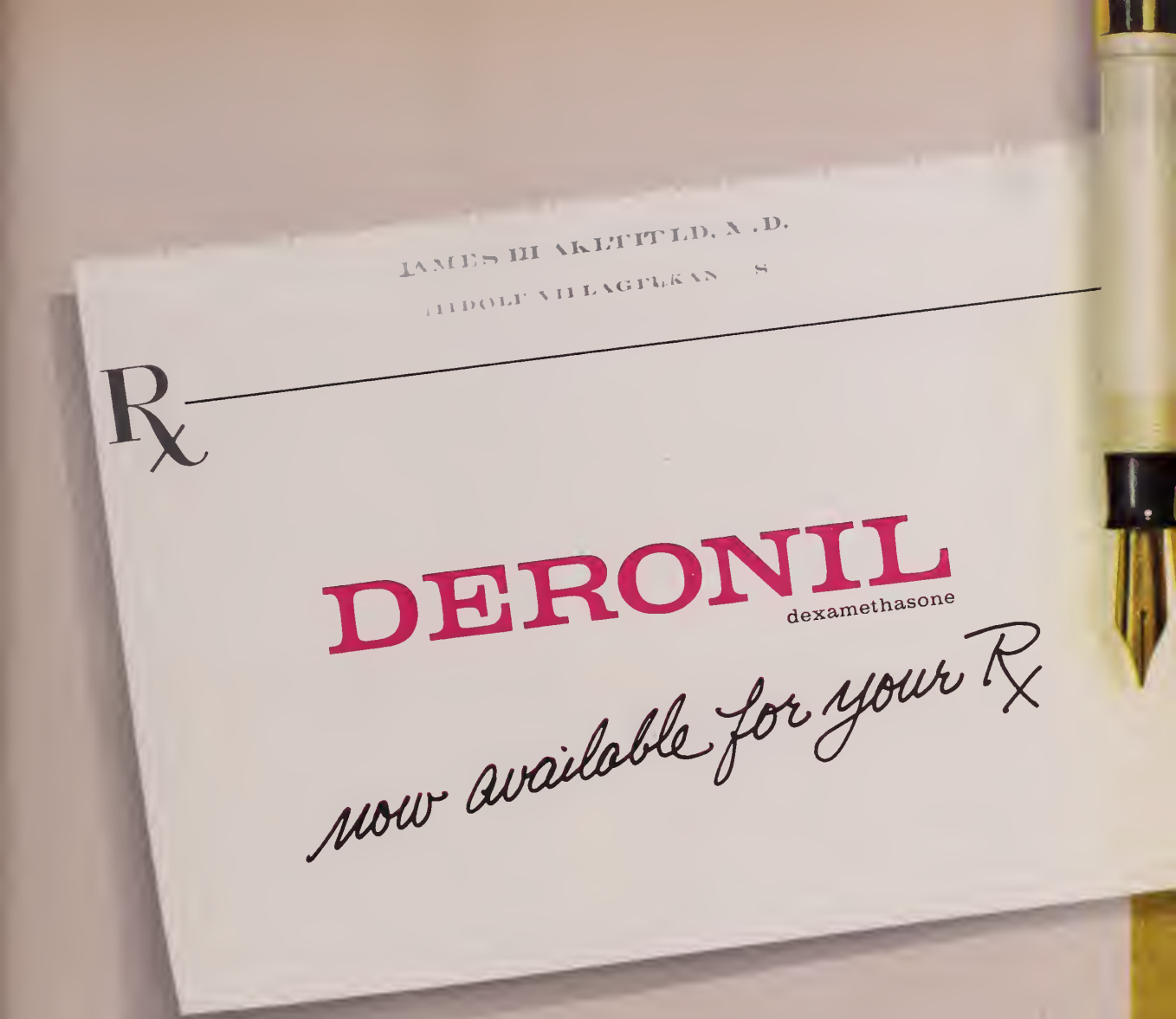
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Essentials For Scientific Progress

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newest steroid

CLINICALLY PREPROVED

maximum
steroid effectiveness in more patients

highest
anti-inflammatory activity per milligram

lowest
dosage of currently used steroids

unexcelled
freedom from significant diabetogenic effects

widest
range of steroid usefulness

Scherin

today's steroid...DERONIL
dexamethasone

in rheumatoid arthritis—"highly effective...in remarkably small daily milligram doses."[1]

The initial anti-inflammatory effect of DERONIL, the most active anti-rheumatic steroid on a weight basis synthesized to date,[1-4] is observed in most patients within 24 to 48 hours. Joint pain is relieved, swelling and stiffness diminish, and range of motion increases. The patient usually feels a sense of well-being and the appetite improves. The intensified anti-inflammatory activity helps assure successful initial therapy in rheumatoid arthritic cases and frequently restores relief to patients who have shown a diminution in response to previous steroids.

TYPICAL RESULTS WITH DEXAMETHASONE THERAPY IN ARTHRITIS

Investigator or Study	No. of patients	Improvement		
		Very marked or marked	Moderate	Slight or inadequate
Boland, E. W., and Headley, N. E.[1]	11	4	5	2
Bunim, J. J., and others[3]	18	5	7	6
Series A[5]	15	4	9	2
Series B[5]	6	6	—	—
Series C[5]	3	3	—	—

DERONIL IN BRONCHIAL ASTHMA AND SEVERE RESPIRATORY ALLERGIES

Investigator or Study	No. of patients	Results		
		Excellent	Fair to good	Poor
Series D[5]	24	10	9	5
Series E[5]	12	8	3	1
Series F[5]	20	13	4	3

clinically preproved in steroid-responsive diseases

IMPROVEMENT WITH DERONIL IN A WIDE VARIETY OF ALLERGIC AND INFLAMMATORY SKIN DISEASES[5]

Disease	No. of patients	Improved	Same	Worse
Seborrheic psoriasis	1	1		
Neurodermatitis	5	5		
Allergic dermatitis	5	5		
Psoriasis	5	2	1	2
Lupus erythematosus, chronic discoid	1		1	
Atopic dermatitis	3	3		
Acne rosacea	1		1	
Nummular eczema	2	2		
"id" reactions	2	2		
Contact dermatitis	2	2		
Pityriasis rosea, severe	1	1		
Urticaria, chronic	1	1		
Totals	29	24	3	2

THERAPY WITH DERONIL IN A VARIETY OF INFLAMMATORY EYE DISEASES[5]

Patient, age and sex	Diagnosis	Symptoms	Results with DERONIL	Side effects
A.B., 46, M.	Postoperative uveitis		Improved; treatment being continued	None reported*
A.E., 53, M.	Choroiditis	Severe choroidal involvement	Excellent; marked improvement	None*
B.F., 60, F.	Acute choroiditis	Marked visual loss and choroidal effect	Marked improvement; therapy being continued	None*
B.K., 29, F.	Chronic uveitis	Generalized involvement	No change despite dosage increase	None*
H.K., 28, M.	Acute iritis	Blurred vision	Excellent; recovered	None*
A.P., 52, M.	Uveitis and perivasculitis	Vision loss to 20/80	Marked improvement; vision 20/30; treatment continued	None*
A.S., 34, M.	Uveitis		Excellent; patient recovered	None*

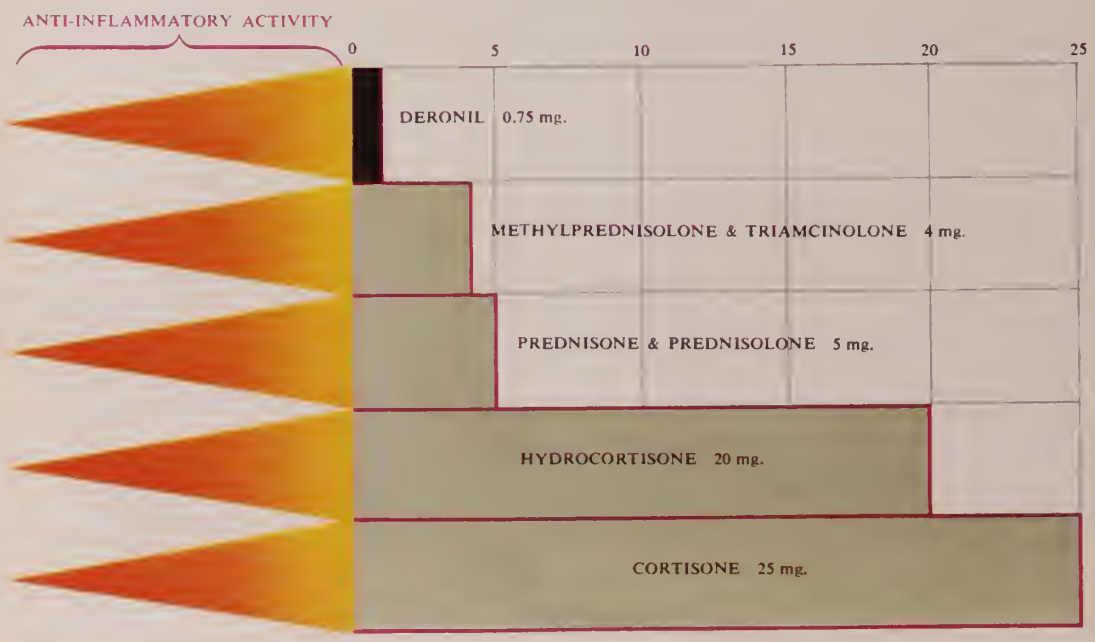
*Short-term therapy (AMA 12/30)

guide to the clinical use of new DERONIL

dexamethasone

DERONIL, new 9-alpha-fluoro-16-alpha-methyl derivative of prednisolone, has at least six times the anti-inflammatory activity, milligram for milligram, of other steroids in current use. Effective dosages are the lowest in steroid therapy. And the price of DERONIL to the patient is no higher than those prevailing for other steroids.

STEROID DOSAGE EQUIVALENTS OF DERONIL



Comparative dosages of corticosteroids for equivalent anti-inflammatory activity

Dosages pre-established in the vast majority of steroid-responsive diseases

The comprehensive clinical studies conducted with DERONIL before introduction mean that initial and maintenance dosages are already established for the physician in practically all steroid-responsive diseases including rheumatoid arthritis, acute rheumatic fever, bursitis, bronchial asthma, pulmonary emphysema and fibrosis, intractable hay fever (pollenosis), disseminated lupus erythematosus, allergic and inflammatory dermatoses and eye diseases and the adrenogenital syndrome. For complete information on dosage, precautions and contraindications, consult Schering literature.

Packaging

DERONIL Tablets, 0.75 mg., scored, bottles of 50 and 500.

Bibliography

(1) Boland, E. W., and Headley, N. E.: Preliminary clinical observations with a new series of synthetic corticosteroid compounds in patients with rheumatoid arthritis, Paper presented at Annual Meet., Am. Rheumat. Assn., San Francisco, June 21, 1958. (2) Boland, E. W.: California Med. *88*:417, 1958. (3) Bunim, J. J., and others: Arthritis and Rheumatism *1*:313, 1958. (4) Spies, T. D.; Stone, R. E., and Niedermeier, W.: South. M. J. *51*:1066, 1958. (5) Reports to Clinical Research Division, Schering Corporation.

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. . . when mental decline
is complicated by
marked agitation

NICOZOL w/Reserpine

helps reverse cerebral
deterioration . . . while it
stimulates body function . . .
and calms the emotions.

for a 3-way synergistic action . . .

Each tablet NICOZOL w/Reserpine contains:

Pentylenetetrazol	100 mg.	(cerebral stimulant & analeptic)
Niacin	50 mg.	(vasodilator)
Reserpine	0.25 mg.	(tranquilizer-sedative)

Clinically Established[1, 2]

In studies of 75 patients (average age—72), with typical mental and emotional symptoms together with alternate periods of depression and agitation, 87% showed gratifying response to NICOZOL w/RESERPINE,

"This therapy afforded relief of agitation . . . improved memory, behavior, sociability, appearance and tidiness. Symptoms of confusion, aggressiveness, hostility and disorientation also were relieved." Fewer side effects were noted.





AT HOME . . . NOT IN A HOME

". . . patients who otherwise would have required institutionalized care were managed at home . . . ."[2]

Prescribed early, NICOZOL w/RESERPINE may avoid "later commitment to nursing homes or state hospitals."[1, 2]

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1. Proctor, R. C.: Clin. Med. 6: 717 (June) 1957
2. Proctor, H. ., Bailey, W. H. and Morehouse, W. G.: J. Am. Geriatrics Soc. (April) 1958.

(Continued from page 1074)

held April 6-9 in the Civic Auditorium at San Francisco. The Congress of Delegates will convene April 4 in the Fairmont Hotel.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, and Dr. Arnold H. Eichert of Hollywood were members of the panel on "Medicine-Dentistry-Psychiatry: A Contemporary Inquiry" presented at the fourth session of the Third Annual Miami Beach Chautauqua Assembly. The first session of the Assembly was held January 5 and the final session on February 23. The title of Dr. Jack's address was "Medicine in This Momentous Era." Dr. Eichert discussed "Phenomenal Advances in Mental Health."

Six additional fellowships for residents in ophthalmology to be awarded July 1, 1959, have been announced by the Guild of Prescription Opticians of America. Applications must be received by May 15, 1959. Applications forms and covering information are available by writing Fellowships, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

An Institute of Hospital Law has been scheduled for March 13-14 at the McAllister Hotel in Miami sponsored by the Florida Medical Association, the Florida Hospital Association, and the Committee on Medico-Legal Law and Procedures of The Florida Bar. Subjects which will be discussed on Friday, the opening day, include "Autopsy Permits and Death Procedures;" "Legal Powers and Responsibilities of the Hospital Trustee in Private and Non-Profit Hospitals;" "Legal Aspects of Nursing," and "Legal Aspects of Medical Records." On Saturday, the subjects will be "Hospital Problems — Legal Aspects," "Legal Liabilities of the Hospitals." The program begins at 9:30 each morning. There will be a registration fee of $10 which includes the luncheon on Friday. Advance registration may be made with Dr. Ben J. Sheppard, Box 579, Coral Gables, or Mr. John Monahan, Executive Director, Florida Hospital Association, P. O. Box 6455, Orlando. Hotel reservations should be made directly with the McAllister Hotel.

Dr. James N. Patterson of Tampa was in Chicago the first of February where he attended meetings of the American Board of Pathology, the Advisory Board of Medical Specialists, and the Congress on Medical Education and Licensure.

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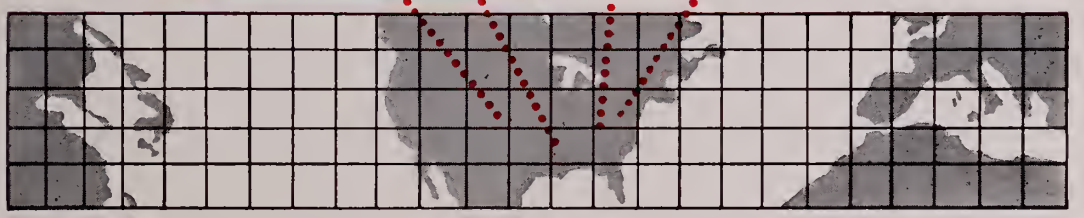
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"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

IN GENERAL
ATARAX IS "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6.Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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COMPONENT SOCIETY NOTES

Brevard

Dr. Duncan T. McEwan, of Orlando, chairman of the Committee on Commercial Health Insurance of the Florida Medical Association, was principal speaker at the February meeting of the Brevard County Medical Society.

Duval

Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, was principal speaker for the January meeting of the Duval County Medical Society. Dr. Annis discussed some of the activities of the Association. At the February meeting, Dr. Karl Jonas, of Philadelphia, delivered an address on the topic "Surgical Treatment of Cancer of the Colon."

Lake

Dr. Glendy Sadler, of Orlando, was guest speaker at the January meeting of the Lake County Medical Society held at Mount Dora. Dr. Lee Rogers Jr., of Cocoa, also attended the meeting.

Pasco-Hernando-Citrus

Dr. Malcolm D. Clayton Jr., of Tampa, was principal speaker at the January meeting of the Pasco-Hernando-Citrus County Medical Society held at Inverness. Guests included Drs. James J. Crumbly and Joseph P. McKell, also of Tampa.

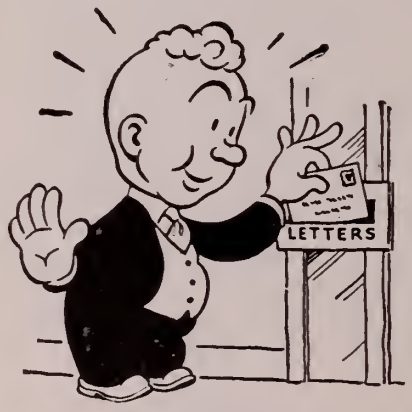
Polk

Dr. Zack Russ Jr., of Tampa, discussed "Modern Approach to Psychiatry" at the January meeting of the Polk County Medical Association. A general discussion period followed the address.

Volusia

Dr. Herbert D. Kerman, of Daytona Beach, was principl speaker at the January meeting of the Volusia County Medical Society. Dr. Kerman discussed the harmful and beneficial uses of x-ray.





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Fiber of skeletal muscle relaxed *(photomicrographs)*



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Summary of six published clinical studies:

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	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
		"excellent"			
O'Doherty & Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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with low incidence of sensitivity reactions... KYNEX is extremely low in toxic potential.[2,3] Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.[2] Also minor subjective reactions are less likely to develop when the recommended dosage is used.[2]

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1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

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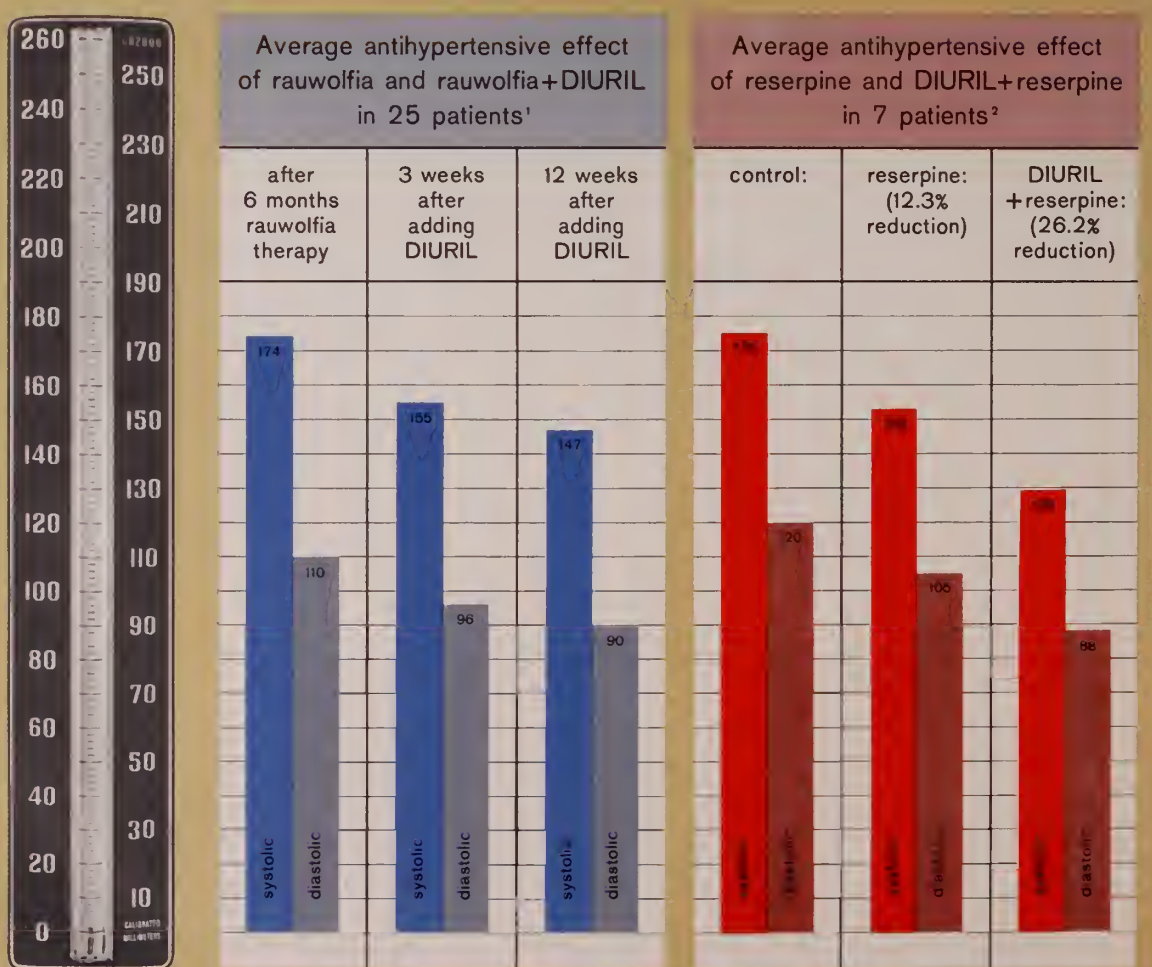
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DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.



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effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

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Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

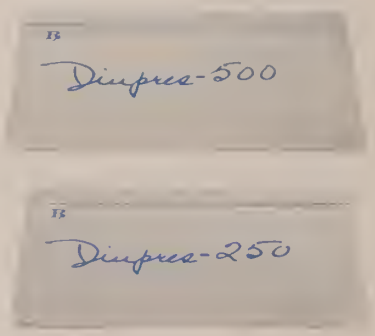
Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride . . . 250 mg.
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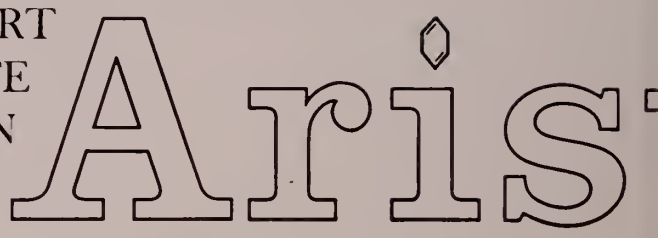
Panmycin (tetracycline) equivalent to tetracycline hydrochloride . . . 125 mg.
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Potassium metaphosphate 100 mg.

Dosage:

Panalba Capsules. Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

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For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

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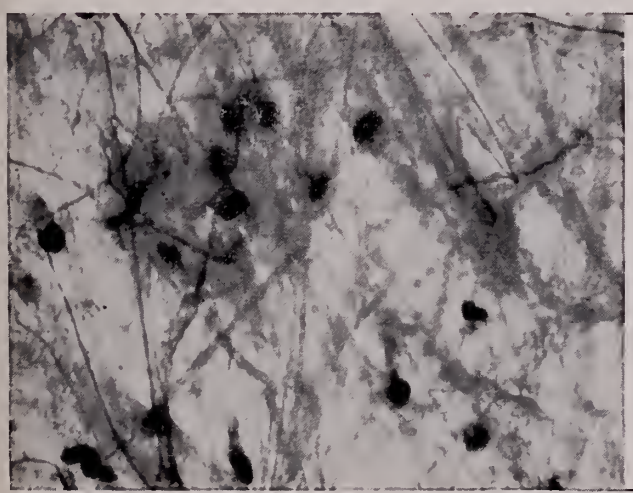
Aristogesic combines the *anti-inflammatory* effects of Aristocort® Triamcinolone with the *analgesic* action of a most potent salicylate. This means that the dosage of each is *substantially lower* than that ordinarily required for each agent alone. With Aristogesic the physician has exceptionally wide latitude in adjusting the dosage to the lowest effective level.

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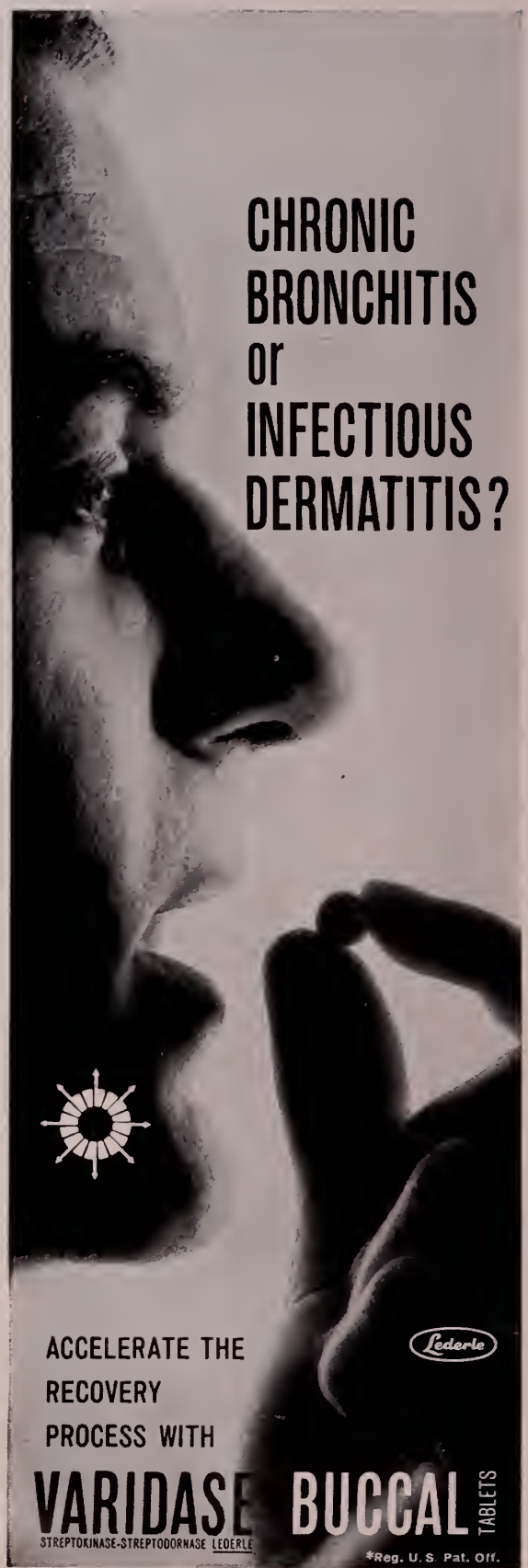
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Memo From the Ladies to the Doctors

As you undoubtedly know, we're hard at work on our annual Today's Health subscription project.

What started all this?

In an editorial appearing in the Dec. 2, 1922, issue of the AMA Journal, the need for a periodical through which the general public might be enlightened in medical science was explained, and the magazine, Hygeia, came off the presses soon after. In the course of time, it became evident that a new name for the magazine was needed, and in 1950, the name was changed to Today's Health. At the same time, the editorial policy was revitalized in an attempt to make people more health conscious with greater emphasis on healthful living, disease prevention and emotional health.

In recent years the American people have clamored for more information about health and medicine. To keep up with this increased public demand, editors of all types of magazines, newspapers and Sunday Supplements have devoted more and more space to articles on health.

Your American Medical Associaton, too, recognized this demand, and now takes great pleasure in introducing the new Today's Health.

As you know, to reach and influence today's sophisticated reader, a magazine must use modern journalism techniques. So the magazine now has: A new cover. A new contents page. Tinted news page. New features. The new Today's Health demonstrates that you members of the American Medical Association are vitally interested in the health of the American family.

What can you do?

You can be proud of the new Today's Health, and you can tell everyone that it is the AMA's

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Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.



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1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

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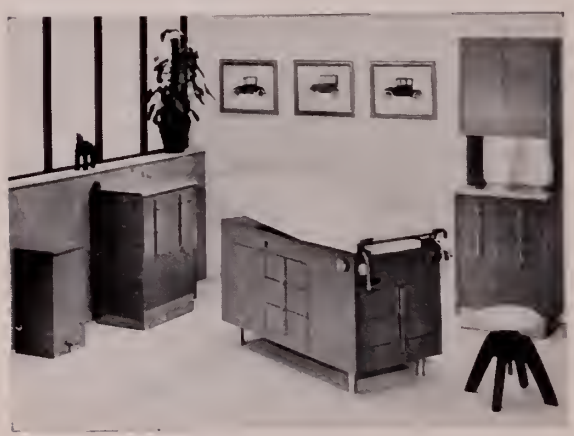
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Striking clinical results with DECADRON are reported† in 92 percent of 319 patients with dermatological disorders, including cases previously unresponsive or resistant to corticosteroids. There were no major complications, and even minor side effects occurred in less than eight percent of patients.

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Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000.

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Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

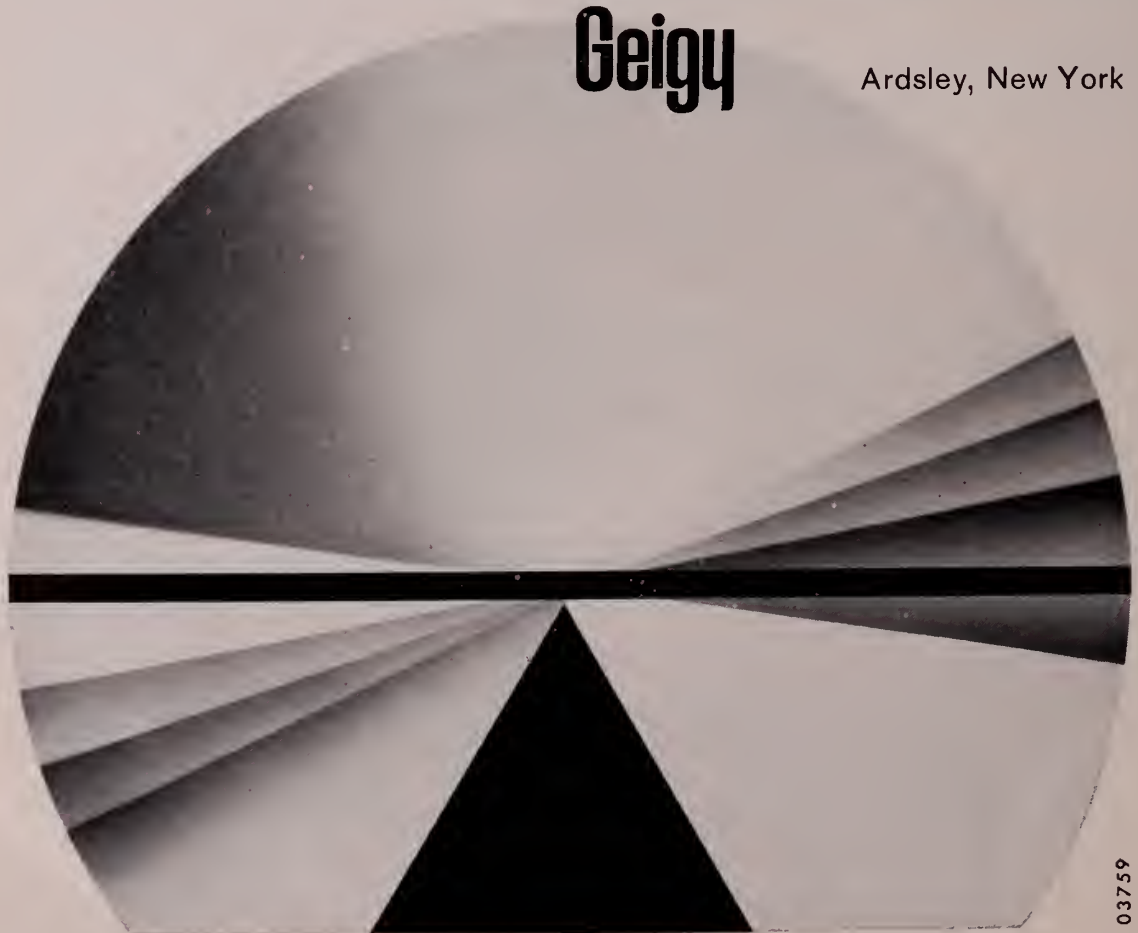
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In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

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BOOKS RECEIVED

Technic and Practice of Psychoanalysis. By Leon J. Saul, M.D. Pp. 244. Price, $8.00. Philadelphia, J. B. Lippincott Company, 1958.

This book offers a clearly expressed and logically presented exposition and discussion of modern psychoanalytic method which considers technic as the natural outgrowth of basic theory and not as something which is the outcome of a set of rigid rules—however reasonable these may be. The author is Professor of Clinical Psychiatry at the Medical School of the University of Pennsylvania. Subjects covered include: goals and attitudes of the analyst, interview technic, free association, unconscious material and dreams, the conduct of the analysis, special problems, sample difficulties and abuses, and progress in and termination of the analysis. Every effort has been made to keep this a realistic and practical consideration of an admittedly controversial subject. A distillate of many years of observation and experience, the book places its principal emphasis on the salient fundamentals of analysis from which all else follows. The author's stated purpose is to describe "how the analyst achieves his insights, how he can understand the individual patient, and how this understanding can be used toward cure." He writes only of the emotional problems of everyday people rather than of patients who are seriously psychotic or insane, and he uses a happy combination of the specialized vocabulary of the professional psychiatrist and language understandable to the well informed layman. Psychiatrists, psychologists, social workers and anyone who has ever gone through analysis or is contemplating doing so will find this a fascinating discussion of what really happens in the analyst's office.

Crime and Insanity. Edited by Richard W. Nice. Pp. 280. Price, $6.00. New York, Philosophical Library, 1958.

This work was prepared in the hope of bringing to light the problem confronting this nation's judiciary system in relationship to the treatment and disposition of the criminally insane. The existing statutes register such tremendous differences in viewpoint, not only from state to state, but as between state and federal government, that some reform seems clearly indicated in a country which prides itself on the fairness of its judiciary system. The provocative symposium here presented by 12 experts in jurisprudence, psychologists, prison psychiatrists, educators and sociologists brings into sharper, more realistic focus this serious judicial problem. The resultant survey, presenting all points of view, will be of peculiar interest to lawyers, doctors and penologists, and should be of equally vital concern to every justice-loving American.

Ciba Foundation Symposium on **The Cerebrospinal Fluid**, *Production, Circulation and Absorption.* Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. Pp. 335. Illus. 141. Price, $9.00. Boston, Little, Brown and Company, 1958.

Recorded in this volume are the proceedings of a Ciba Foundation symposium which attracted anatomists, neurologists, pathologists, psychiatrists, pharmacologists and neurosurgeons from all over the world, who came to contribute the distilled products of their research and reflections. Among the many questions considered were: How accurate is present information about the anatomy of the pia-arachnoid, of the arachnoid villi, of the choroid plexuses, of the innervation and vascularization of these structures, and of the arrangement and significance of the subarachnoid, perivascular and perineuronal spaces? Do we really know where, how and why the cerebrospinal fluid is produced and absorbed, and is it a



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stimulates the appetite,

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1. Landes, R. P. and Peters, M.: Postgrad. Med. 23:648, June 1958.

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The Low Calorie Diet

A diet that calls for lamb chops when they aren't on the restaurant menu is an invitation to "slip off." But a diet outline that lets your patient fill in the details provides incentive to stick to his diet.

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Never more, never less.

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No risk of
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no hot-weather
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VITERRA PEDIATRIC. How will
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On cereal? Straight from the
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B_6 (Pyridoxine)	1 mg	††	††
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(*Continued from page 1099*)

secretion, excretion, or transudate? Is the process under nervous or hormonal control, are there secretory granules in the choroidal epithelium, and what is the true function of the choroid plexuses? Can we explain the blood-brain and blood-cerebrospinal fluid barriers and their variations at different ages and in different regions? By what means and for what reason does the cerebrospinal fluid circulate? And how may all of these fundamental considerations be correlated with clinicopathologic observations or utilized to determine the most rational modes of treatment? The papers and discussions throw into sharp focus that few definite data exist in this area. The consensus of the participants reveals that we do not know exactly how this fluid is produced, circulated, or absorbed. The book offers stimulating reading and should be of much interest to many categories of research workers and clinicians.

Ciba Foundation Symposium on the **Neurological Basis of Behaviour.** Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecelia M. O'Connor, B.Sc. Pp. 400. Illus. 109. Price, $9.00. Boston, Little, Brown and Company, 1958.

This book records the great success and interesting conclusions of a memorable Ciba Foundation symposium on the interrelations of neural and behavioral mechanisms in which many distinguished specialists in the field from European countries, Canada and the United States participated. The discussion was lively and significant. It became clear that the future of psychiatry seems likely to be closely linked with the development of this new field of science which attempts to place psychology on a basis of neurophysiology. The material discussed at the symposium ranged from microphysiology of neuroses to phenomena of behavior and psychology. Electrophysiologic approaches loomed large in the review of the various technics employed in the study of the neurologic substratum of behavior. Analytic, biologic, clinical and strictly behavioral methods were also discussed at length.

Epilepsy. By Manfred Sakel, M.D. Pp. 204. Price, $5.00. New York, Philosophical Library, 1958.

It has been a mere three decades since the late Dr. Manfred Sakel made his revolutionary discovery of the insulin treatment of mental disease—the first great biochemical approach to psychotherapy. It was his unique contribution to strike a mortal blow to the dogma of the predestined outcome of hereditary psychoses and to prove specifically that the schizophrenic psychoses were amenable to treatment. This monograph on Epilepsy is one of his major works and his final work before his untimely death. His early study on this subject at the time when he had brought his insulin shock therapy to its definite success in 1934 led to new and important points of view. During his last years, he renewed his interest in the management of epilepsy and upon his death left behind an uncompleted manuscript, expounding his theories on the mechanism and therapy of this still unconquered disease. Here, then, is a document of historical interest, a great doctor's last contribution to medical literature. No attempt has been made to alter Sakel's original material, though it has been annotated and brought up to date under the guidance of several neurologists and psychiatrists. It is published now as an intriguing contribution to medical literature, of interest to practitioner and student alike, and a fitting monument to the life work of a noble pioneer.

Schizophrenia. By Manfred Sakel, M.D. Pp. 335. Price, $5.00. New York, Philosophical Library, 1958.

This is a definite work on a relatively new frontier in medicine, from the physician who opened it to the world, and was, until his recent death, its foremost authority. Until Dr. Manfred Sakel discovered and developed the treatment that bears his name, sufferers from schizophrenia were given up as hopeless. His contribution to this greatest single problem in psychiatry and mental hospitals, the Sakel Insulin Therapy, not only revolutionized medicine's whole attitude toward endogenic psychoses, but has given new life and hope to thousands of mental patients and their families throughout the world. This book presents his personal account of his epoch-making discovery, its clinical operation, and its consequences for psychotherapy. Part I investigates the "theoretical" background—the history and description of schizophrenia, the doctors and scientists who contributed to this new branch of medicine, the causes and classifications of the illness, and the symptoms, diagnosis and prognosis. Part II is devoted to Sakel's own clinical description of his treatment, with full medical data and detailed records of many case histories.

Poisoning. *A Guide to Clinical Diagnosis and Treatment.* By W. F. von Oettingen, M.D., Ph.D. Ed. 2. Pp. 627. Price, $12.50. Philadelphia, W. B. Saunders Company, 1958.

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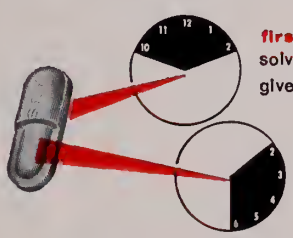
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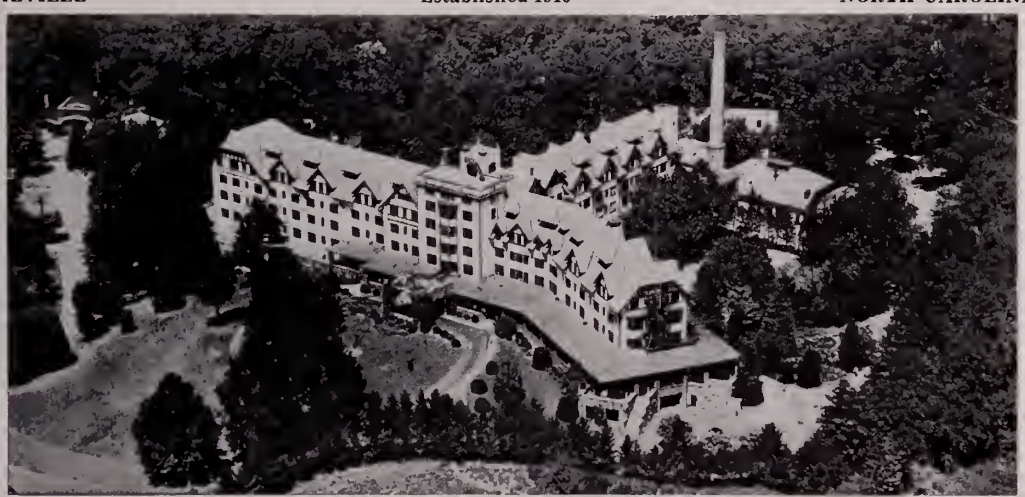
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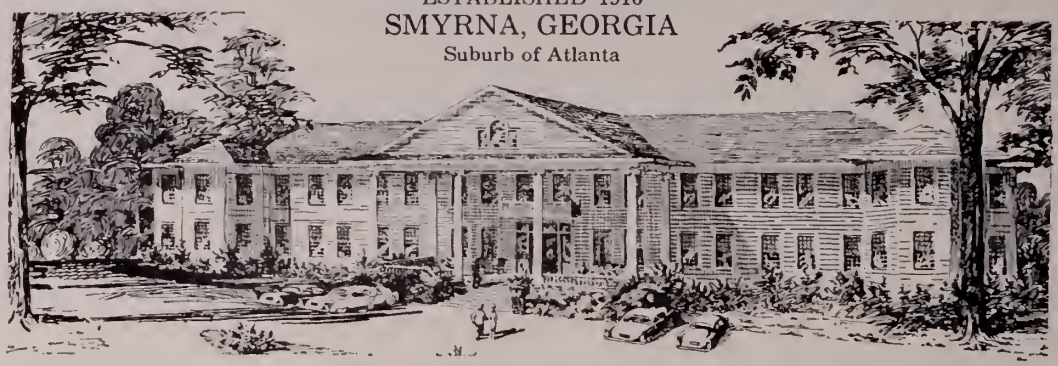
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Bay	James D. Nixon, Panama City		2nd Tues.	31
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	59
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	223
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
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DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	355
* *Clay*				
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Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	234
Indian River	B. Bowman Guerin, Vero Beach		2nd Tues.	11
Jackson-Calhoun	Glenn E. Padgett, Marianna	Frances M. Watson, Marianna	Quarterly	15
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	29
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Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	291
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(1) Rubin, A., and Babbott, D.: J.A.M.A. *168*:498, (Oct. 4) 1958. (2) Kinsey, A. C.; Pomeroy, W. B., and Martin, C. E.: Sexual Behavior in the Human Male, Philadelphia, W. B. Saunders Company, 1948.

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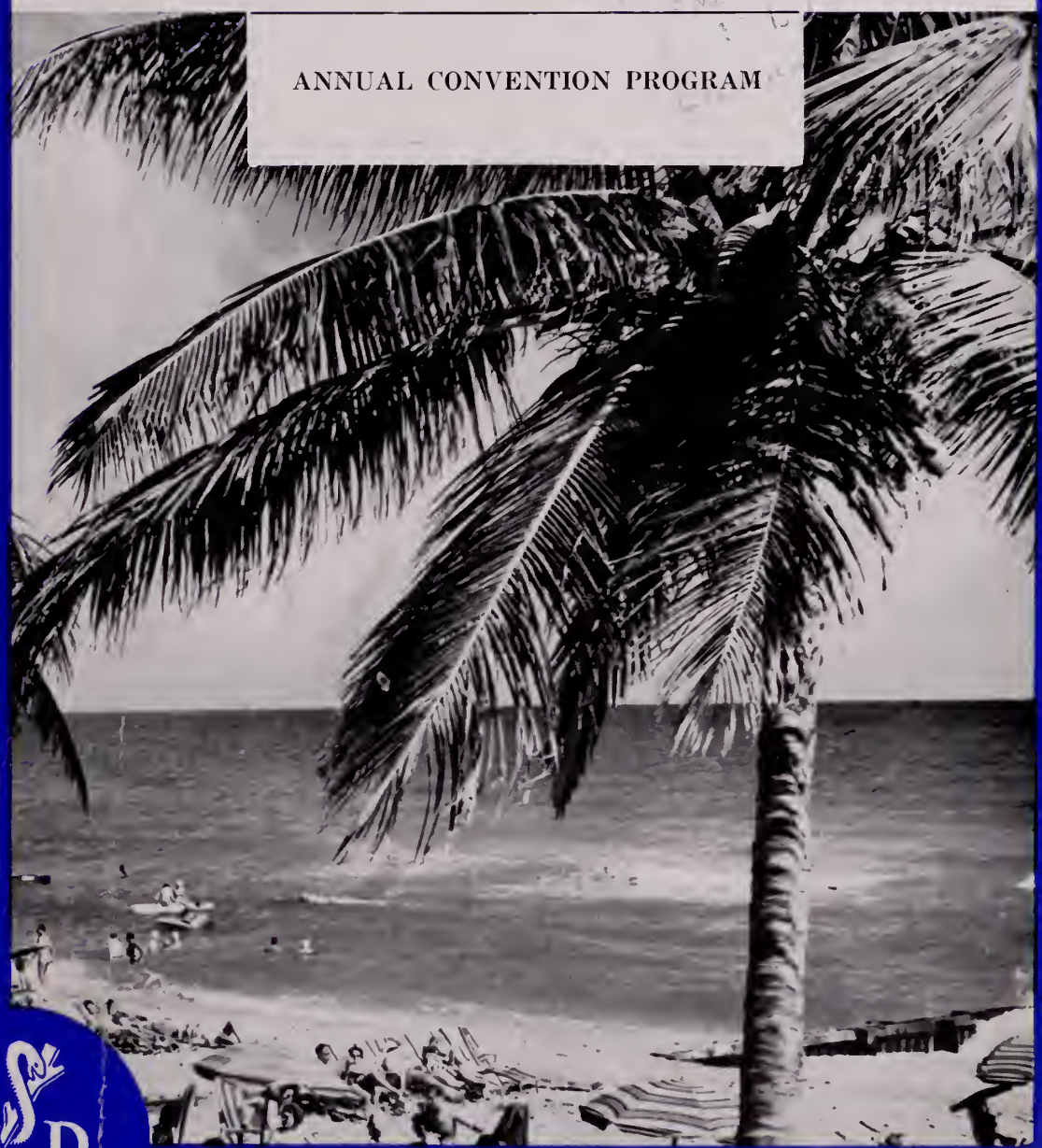
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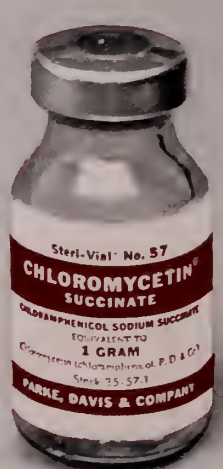
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Shigella dysentery[3]	14	14		
Enteritis[3]	10	6	2	2
Bacteremia[3,5]	5	5		
Meningitis[3,5]	4	3		1**
Rocky Mountain spotted fever[3,5]	2	2		
Ear abscess with cellulitis[4]	1	1		
Lung abscess[4]	1			1
Typhoid fever[5]	1	1		
TOTALS	70	64	2	4

*Includes 15 patients who were administered CHLOROMYCETIN SUCCINATE by nebulization under intermittent positive pressure breathing.

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REFERENCES—(1) Glazko, A. J., *et al.*, in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 792. (2) Unpublished data: Research Laboratories, Parke, Davis & Company, 1958. (3) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (4) Payne, H. M., & Hackney, R. L., Jr.: *ibid.*, p. 821. (5) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837.

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for
CERTAINTY
against
the
COCCI
Erythrocin® stearate
(Erythromycin Stearate, Abbott)
an uncommon antibiotic for common infections

after millions of prescriptions ...an unparalleled safety record

provides fast, high blood and tissue concentrations

Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes. High, peak levels occur between one and two hours—and effective concentrations are maintained for at least six hours. Always at hand, then, against more critical infections is ERYTHROCIN-I.M.—the only intramuscular form of erythromycin available.

backed by years of clinical effectiveness

Actually, every prescription you write for ERYTHROCIN is backed by more than six years of clinical effectiveness against coccal infections. And, with the problem of antibiotic resistance becoming more important daily, the value of ERYTHROCIN as a day-to-day anticoccal agent is dramatically underlined.

supported by an unparalleled safety record

During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad-spectrum" action, the normal flora of the intestinal tract is virtually unaltered with ERYTHROCIN therapy.

offers bactericidal activity

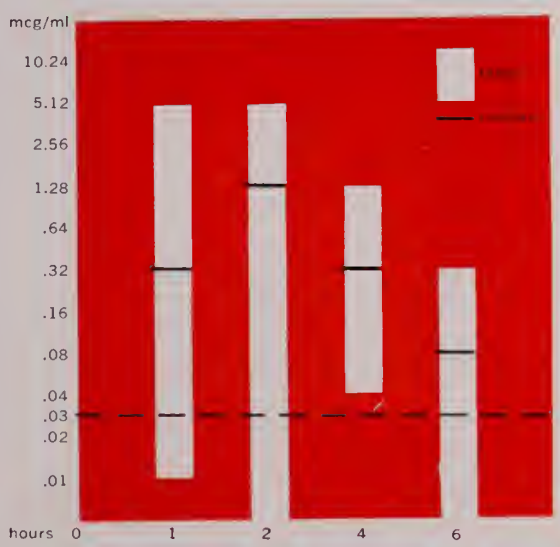
Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal antibiotic. It offers lethal action against common coccic invaders—resulting in prompt clinical response.

provides convenient dosage forms

Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also in oral suspension and for intramuscular use. Won't you prescribe ERYTHROCIN doctor? Abbott

if you're concerned with blood levels...

Dotted line shows actual inhibitory concentrations against most organisms. Note the high ranges and medians of ERYTHROCIN Stearate at one, two, four and six hours. Data represents three studies with adults. Each was given one 250-mg. Filmtab.



And where you need a consistent uniform response that only an injectable form can provide, remember—**ERYTHROCIN-I.M.**(Erythromycin Ethyl Succinate, Abbott) and **ERYTHROCIN LACTOBIONATE.**

®*Filmtab—Film-sealed tablets, Abbott; pat. applied for.*

new **for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions**

Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

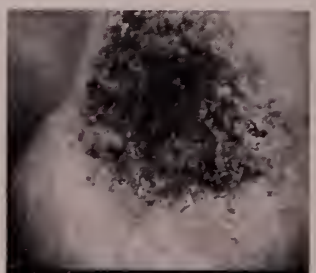
antipruritic/anti-inflammatory/antibacterial/antifungal



Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment – containing the new superior topical corticoid Kenalog – reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] – neomycin and gramicidin for powerful antibacterial action[7] – and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3 123 (Nov.) 1958. • 3. Robinson, R.C.V. Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H. Newcomer, V.O., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Moncgraphs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

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Squibb Quality — the Priceless Ingredient

"SPECTROCIN"®, "MYCOSTATIN"®, "PLASTIBASE"®, "MYCOLOG" AND "KENALOG" ARE SQUIBB TRADEMARKS

AN UNSURPASSED SYSTEMIC IODINE BY ANY PRACTICAL COMPARISON

ORGANIDIN®

(brand of iodinated glycerol)

Unexcelled stability, with full effectiveness

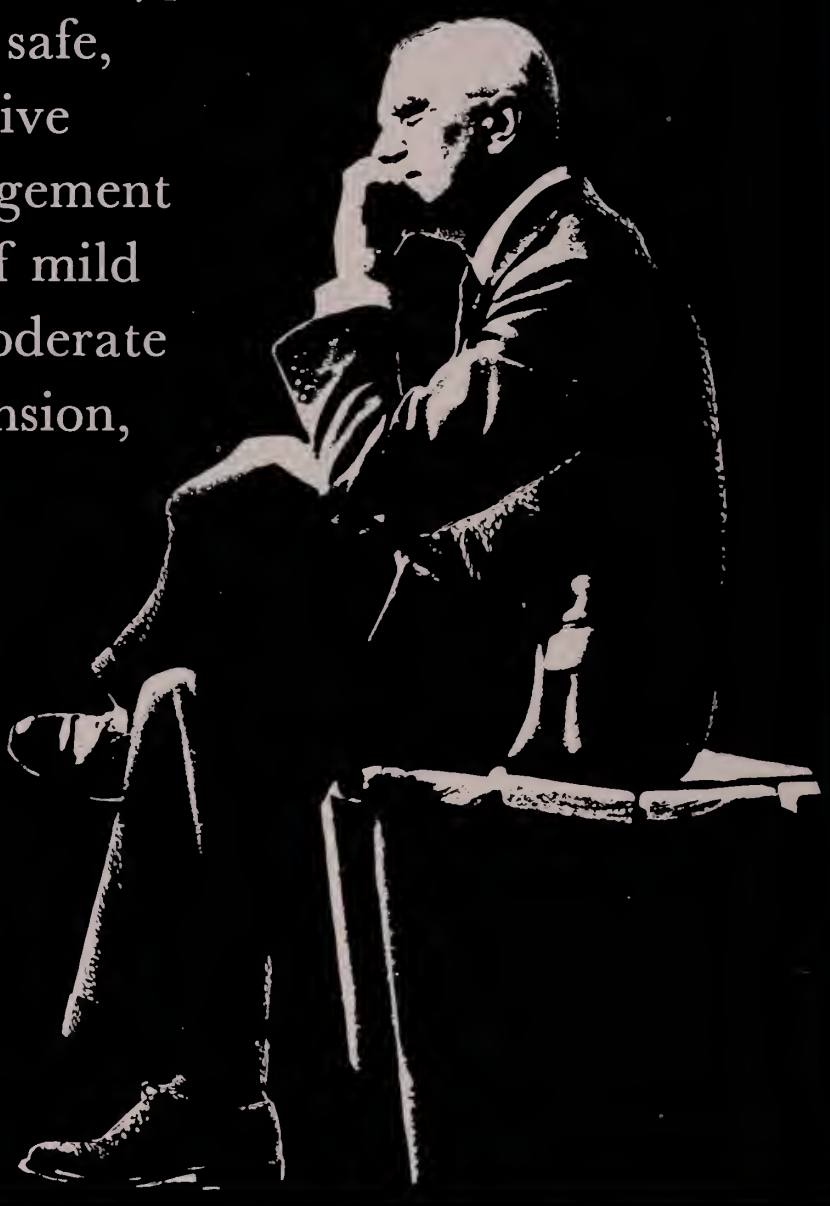
Smooth, even absorption

Well tolerated any time—and inexpensive

ORGANIDIN retains potency indefinitely while Lugol's solution and potassium iodide solution change composition on standing. ORGANIDIN is readily and rapidly absorbed. ORGANIDIN dosage *can begin at therapeutic level*—effect is smooth and sustained. Since the iodine in ORGANIDIN is *organically bound* it is well tolerated, more so than potassium iodide,[1] and permits more prolonged, uninterrupted therapy.[2] Whenever you consider iodine therapy, prescribe ORGANIDIN solution or tablets—unexcelled and inexpensive therapy. *Indications:* Expectorant in asthma, bronchitis, and similar forms of pulmonary congestion, goiter prophylaxis, and as an adjunct in simple goiter and thyrotoxicosis. For complete dosage and supply information, see page 847 of your Physicians' Desk Reference. *References:* 1. Seltzer, A.: M. Ann District of Columbia *26*:17, 1957. 2. Slaughter, D: South Dakota J. Med. & Pharm *1*:125, 1940.

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Prescribed with confidence 8,863,769 times Veratrite continues to be the antihypertensive of choice for treating geriatric patients.

Veratrite effectively reduces blood pressure through action on the sympathetic nervous system, without detriment to the cardiac output.

Each VERATRITE tabule contains:

Cryptenamine (tannates) 40 C.S.R.* Units	
Sodium nitrite	1 gr.
Phenobarbital	¼ gr.

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Neisler

2½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

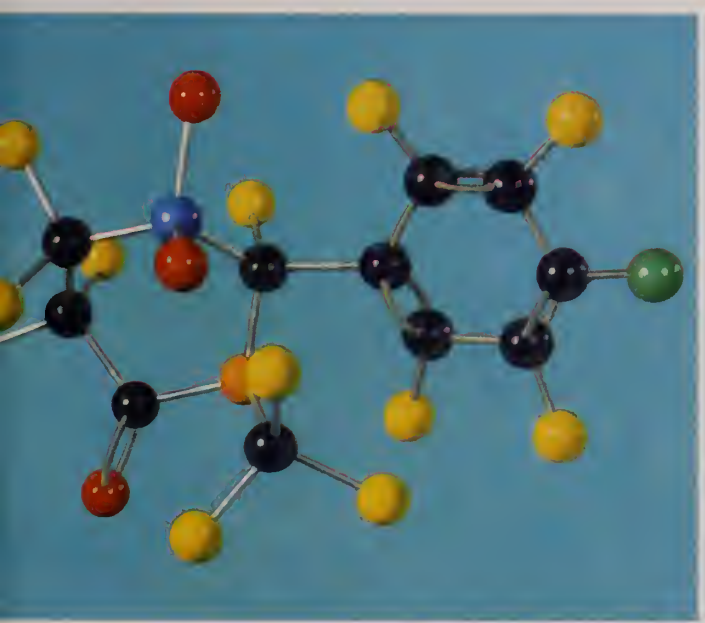
Trancopal®

*the first true tranquilaxant**

Potent MUSCLE RELAXANT

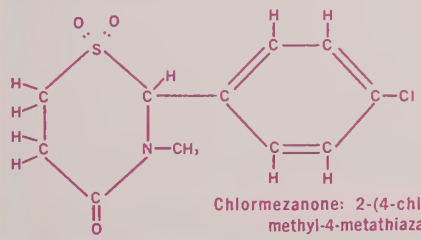
...Equally effective as a TRANQUILIZER

*** tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in 91% of patients

INDICATIONS

Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias
Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

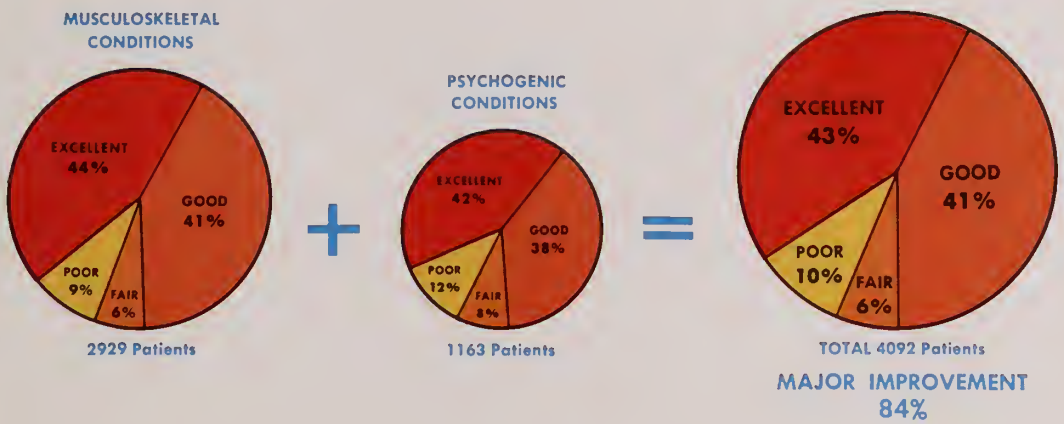
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "...allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



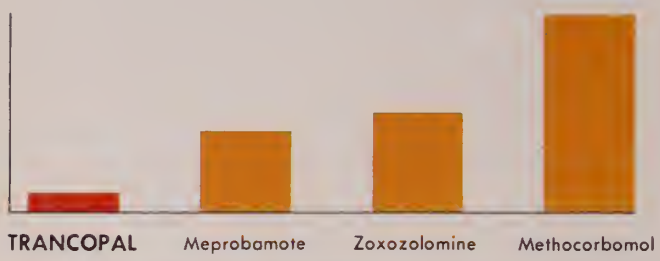
Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage.
Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

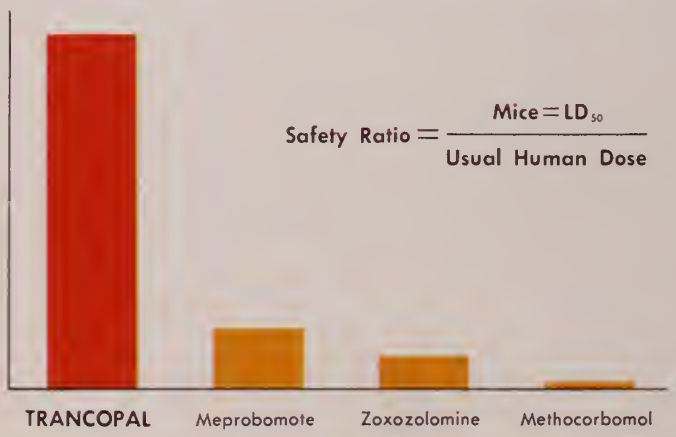
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness, Trancopal offers definite desirable advantages.



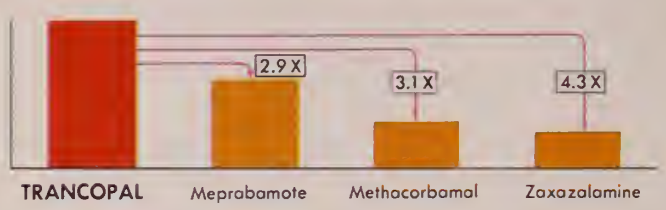
for activity

In the usual human dose, Trancopal is four to ten times as potent per milligram.



for safety

Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of the 40 patients received all four drugs in random rotation for several days. Although each of the four gave some relief, only the one providing the most effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. • 2. Gans, S.E.: To be published. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

Trancopal

Potent
MUSCLE RELAXANT
...Equally effective as a
TRANQUILIZER

Winthrop Laboratories / New York 18, New York

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

Printed in U. S. A. 3-59 (40)

as
they
like
it...

cherry-flavored

syrup pediatric drops



as
they
need
it...

ACHROMYCIN® V

Tetracycline with Citric Acid Lederle

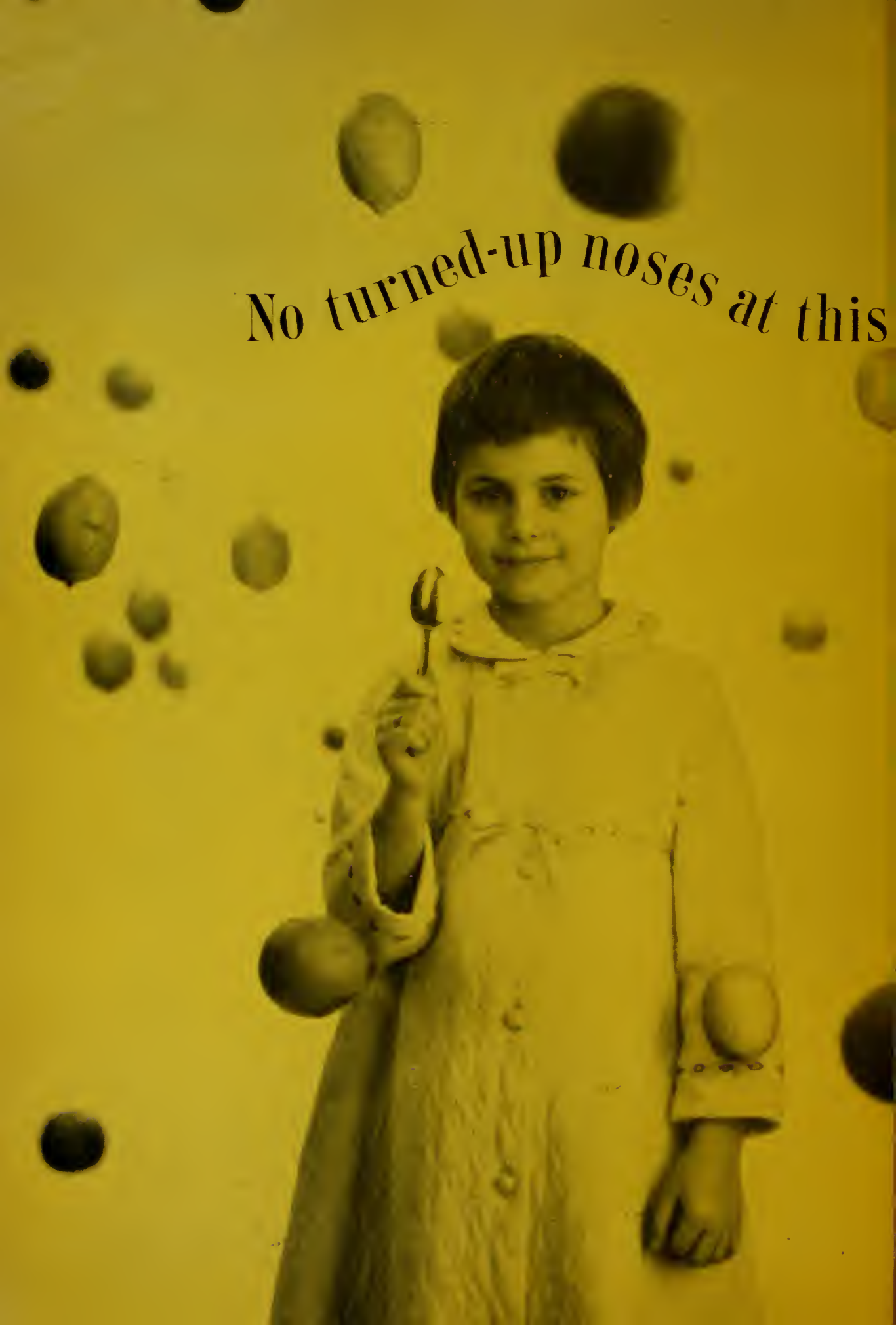
- broad spectrum control of more than 90 per cent of antibiotic-susceptible infections seen in general practice[1]
- fast, high concentrations in body fluids and tissues
- no irreversible side effects reported, excellently tolerated
- readily miscible in water, juices, formula.

ACHROMYCIN V: 10 cc. plastic dropper bottle for precise dosage; 100 mg. per cc. (20 drops). *Dosage:* one drop per pound body weight per day.

ACHROMYCIN V Syrup: Each teaspoonful (5cc.) contains equiv. 125 mg. tetracycline HCl. Bottles of 2 and 16 fl. oz. *Dosage:* at 45 lbs., one teaspoonful 4 times daily; adjust for other weights.

1. *Based on six-month National Physicians Survey.*

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York


No turned-up noses at this

new erythromycin suspension

CITRUS-FLAVORED

ERYTHROCIN®

Ethyl Succinate

ORAL SUSPENSION

a new derivative of erythromycin designed especially for children

Never a flavor like this in an antibiotic suspension

A new achievement in pharmaceutical elegance—a ready-mixed stable suspension so sweet and good you can't tell it's "medicine." No bitterness, no unpleasant aftertaste—just pure, sweet citrus flavor.

Never an antibiotic better proved against everyday coccal infections

After millions of prescriptions, an unexcelled safety record. High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, Erythrocin is classed as a bactericidal antibiotic.

INDICATIONS: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. DOSAGE: For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm. daily, depending on severity of infection. SUPPLIED: in 60-cc., pour-lip bottles. Each 5-cc. teaspoonful represents 200-mg. of Erythrocin activity.

Abbott

®ERYTHROMYCIN ETHYL SUCCINATE, ABBOTT

Why G.I. patients abandon therapy

Bandes[1] reports that G.I. patients often abandon therapy because of the unpleasant side effects of the prescribed drugs–blurred vision, dry mouth and loginess.

In a clinical trial of such patients who had abandoned other therapy, 90% had gratifying relief of symptoms, and 85% were free of *any* side effects on

Milpath®

®Miltown + *anticholinergic*

Direct antispasmodic action, plus control of anxiety and tension, provide rapid, safe relief of pain, spasm and anxiety—without the side effects of belladonna, bromides or barbiturates.

FORMULA: Each scored tablet contains:
meprobamate 400 mg., tridihexethyl chloride 25 mg.
(formerly supplied as the iodide).

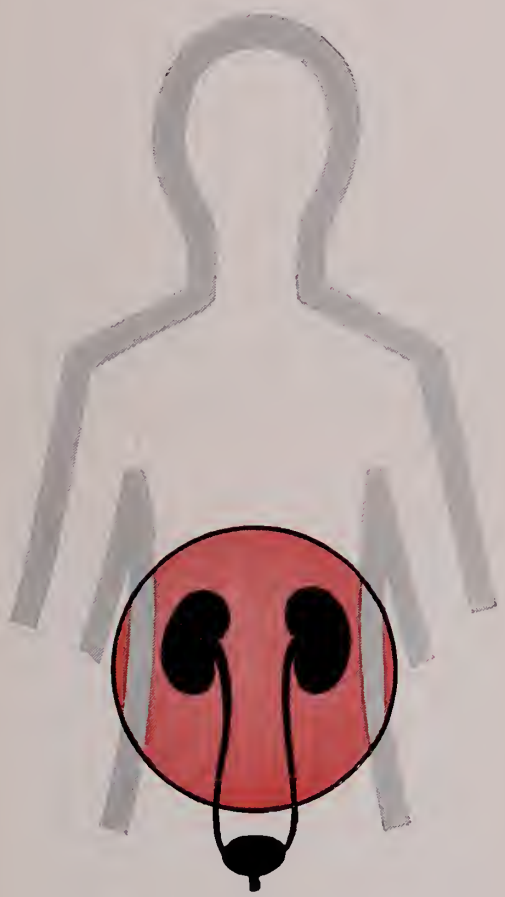
DOSAGE: 1 tablet t.i.d., with meals, and two at bedtime.

1. Bandes, J.: Combined Drug Therapy in Gastrointestinal Disturbances; Increased benefit through diminished side reactions, Am. J. Gastroenterology, *30*:600, Dec. 1958.

WALLACE LABORATORIES *New Brunswick, N. J.*

URIPLEX *alone*

FULFILLS THE MAJOR THERAPEUTIC OBJECTIVES IN URINARY TRACT INFECTIONS



Safe, potent antibacterial action proven effective in 95% of all urinary tract infections.

Prompt relief of spasm all along the urinary tract.

Specific urinary analgesic action relieves burning and pain within minutes.

THE *COMPLETE* THERAPY FOR URINARY INFECTIONS

Uriplex, in addition to accomplishing these major objectives, offers more rapid and complete control of urgency and frequency because of its simultaneous relief of both pain and spasm.

Each Uriplex coated tablet contains:

Sulfacetamide	250 mg.
Methscopolamine Nitrate	1 mg.
Phenylazodiaminopyridine HCl	50 mg.

LLOYD, DABNEY & WESTERFIELD, INC. • Cincinnati 9, Ohio

Fine Pharmaceuticals Since 1894

the higher
blood levels of
potassium
penicillin V

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FOR
THOSE
COMMON
BACTERIAL
PROBLEMS



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IN FILMTAB® / IN ORAL SOLUTION
AND IN COMBINATION WITH SULFAS

illin®-VK

(POTASSIUM PENICILLIN V)

INDICATIONS

Against all penicillin-sensitive organisms. When combined with Sulfas, COMPOCILLIN-VK is especially effective in treating mixed infections such as may occur in the respiratory or urinary tract.

DOSAGE

Range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. Children's dosage is determined by body weight. When combined with sulfa triad, range is one Filmtab three times daily to two Filmtabs every four hours.

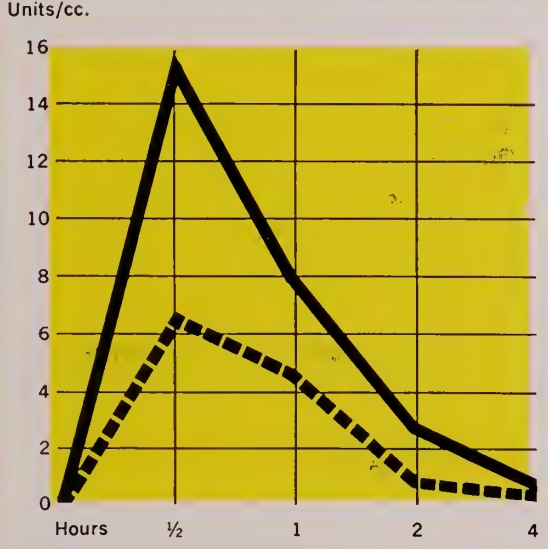
SUPPLIED

COMPOCILLIN-VK Filmtabs: 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100.

COMPOCILLIN-VK Granules for Oral Solution: In 40-cc. and 80-cc. bottles. When reconstituted, each tasty 5-cc. teaspoonful of cherry-flavored solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-VK with Sulfas: Each Filmtab contains 125 mg. (200,000 units) of potassium penicillin V and 500 mg. of sulfonamides. At all pharmacies.

Abbott



The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before meal-time to 40 subjects involved in this study.

®FILMTAB—FILM SEALED TABLETS, ABBOTT. PAT. APPLIED FOR.

STOP

all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

Each* TUSSAGESIC *Tablet contains:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextro-methorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-para-aminophenol)	325 mg.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

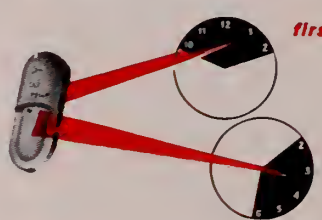
Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

To reduce upper respiratory congestion and irritating secretions.

For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

For specific, highly effective antipyresis and analgesia.



first —3 to 4 hours of relief from the outer layer

then —3 to 4 more hours of relief from the inner core

Also available—for those who prefer palatable liquid medication— Tussagesic suspension

NEW

Tussagesic

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Four weeks ago, Mrs. C. was an anxiety patient, complaining of weakness, trembling, sweating, tachycardia, on the slightest exertion. Her symptoms followed family reverses; home life became disorganized, she couldn't cope with housework. Therapy with 4 mg. t.i.d., and a weekly office visit to discuss her feelings have worked wonders in reactivating this patient. She's on maintenance dosage now, 2 mg. t.i.d., able to work very well, and wide-awake and active all day long.

mobilizes patients immobilized by anxiety

when you want to avoid drowsiness

- helps the patient contain anxiety, tension
- restores normal working capacity

TRILAFON Tablets—2 mg. and 4 mg.; bottles of 50 and 500.
TRILAFON REPETABS,® 8 mg.—4 mg. for *prompt* effect in the outer layer and 4 mg. for *prolonged relief* in the timed-action inner core; bottles of 30 and 100.
For complete details on TRILAFON consult Schering literature.

Schering

TR-J-820



V-CILLIN K®...

dependable, fast, effective therapy

V-Cillin K produces therapeutic blood levels in all patients within five to fifteen minutes after administration—levels higher than those attained with any other oral penicillin. Infections resolve rapidly. *Dosage:* 125 or 250 mg. three times daily. *Supplied:* In scored tablets of 125 and 250 mg. (200,000 and 400,000 units).

New: V-Cillin K® Sulfa. Each tablet combines 125 mg. of V-Cillin K with 0.5 Gm. of the three preferred sulfonamides.

New: V-Cillin K, Pediatric, a taste treat for young patients. In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. of V-Cillin K.

V-Cillin K® (penicillin V potassium, Lilly)
V-Cillin K® Sulfa (penicillin V potassium with triple sulfas, Lilly)

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The Journal of the Florida Medical Association
PUBLISHED MONTHLY

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A Physiologic Basis for Peptic Ulcer Surgery

Edward R. Woodward, M.D.
GAINESVILLE

There are few subjects in surgery about which more controversy has existed and in which more new operations have been proposed than that of the surgical treatment of peptic ulcer. Osler referred to duodenal ulcer as "the wound stripe of civilization," and it is generally considered to be one of the so-called psychosomatic disorders. The evidence indicating the importance of the central nervous system in the pathogenesis of peptic ulcer is voluminous and convincing, but there is still much that is poorly understood about the mechanisms involved. Surgery for this disease has been aimed at the local pathology, the peripheral mechanism, the "target organ." Since the basic etiologic factors have not been attacked, it is not surprising that the results of surgery have been somewhat less than ideal.

It would not be possible to discuss all the various aspects of the subject chosen for today, and I will therefore limit this presentation to two main pathophysiologic considerations I believe to be important to the surgeon. First is the concept that the disturbed physiology in gastic ulcer is completely different from that in duodenal ulcer, and second is the thought that the overproduction of acid gastric juice in duodenal ulcer is related to the pathogenesis of this disease and is an important clue to its surgical control.

Clinical Differences in Gastric and Duodenal Ulcer

Benign gastric ulcer has striking clinical differences from duodenal ulcer in the sex and age groups involved, the complications encountered, and the response to medical therapy. Even more striking is the remarkable difference in the functional state of the stomach. In the patient with duodenal ulcer there is pronounced hypermotility of the stomach with rapid almost precipitate emptying and frequent deep waves of peristaltic contractions. In contrast, the patient with gastric ulcer has diminished motility with sparse contractions and prolonged retention in the stomach of either barium or food materials. This is probably related to the much greater frequency of vomiting and loss in weight in patients with gastric ulcer as compared with those suffering from nonobstructing duodenal ulcer.

The secretion of acid gastric juice is also depressed in patients with gastric ulcer. Not only is it much less than in patients with duodenal ulcer, but the basal gastric secretory rate is even lower than in normal persons.[1] Frequently in the patient with gastric ulcer no free acid will be demonstrated in the aspirate from the fasting stomach, and rather vigorous stimulation with histamine may be required to demonstrate the ability of the stomach to produce hydrochloric acid.

These two outstanding pathophysiologic differences between gastric and duodenal ulcer added to the known clinical differences between the two lead one to the inescapable conclusion that they are two entirely different diseases. Because of its occurrence in an older age group, gastric ulcer may be related to a vascular disturbance. An area of decreased blood supply in the stomach wall might well have a reduced resistance to the corrosive action of acid-pepsin.

Dragstedt and his associates[2] theorized that the gastric retention in the patient with gastric ulcer may cause hyperstimulation of the gastric antrum with excessive release of the hormone, gastrin, stimulating acid gastric secretion. In support of this theory is the curative effect of simple resection of the antral portion of the stomach distal to the gastric ulcer—the Kelling-Madelener operation. Even a huge ulcer left in situ as part of such an operation will promptly heal in the postoperative period and will not recur.

From the Department of Surgery, College of Medicine, University of Florida, Gainesville.
Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

Surgical Treatment of Benign Gastric Ulcer

The surgical treatment of choice in benign gastric ulcer is conservative partial gastrectomy (antrectomy or antrum resection). The extremely low rate of postoperative recurrence of ulceration makes surgery a most efficient treatment for benign gastric ulcer, and justifies its rather free application in this disease. Radical operation is not necessary since an unremoved ulcer will promptly heal. The diagnosis of malignant disease is made with such accuracy, by using all diagnostic means available and including when necessary direct vision and biopsy, that this possibility does not justify radical surgery.

The "test of healing" is a useful method for selecting patients for surgery (table 1).[3] In 100 consecutive cases of gastric ulcer in patients admitted to the Wadsworth Hospital, Veterans Administration Center, Los Angeles, the lesion healed promptly in 40 on an intensive medical regimen during the period of hospitalization. In 14 patients the gastric ulcer healed promptly, but there was a recurrence in less than two years. In all, the recurring lesion proved to be benign. Forty-six patients did not show complete healing of the crater during the four week test period and were subjected immediately to exploration and gastric resection. In 41 the lesion proved to be benign, while in five it was malignant and radical gastrectomy was performed.

Table 1.—Gastric Ulcer—100 Consecutive Cases

Healed promptly and remained healed		40
Healed promptly but recurred—all benign		14
Failed "test of healing"		46
Benign	41	
Malignant	5	

The low recurrence rate following conservative surgery for benign gastric ulcer is most likely related to the low rate of acid gastric secretion. This factor also makes it entirely safe to use the Schumaker-Billroth I type of end to end gastroduodenostomy. This not only has clearcut surgical advantages, but is also worth while from the physiologic point of view. Food is routed through the normal passage preserving the digesting and absorbing function of the duodenum, and the digestion of fat, in particular, is definitely superior to that in the usual gastrojejunal reconstruction. Also, the disagreeable postoperative disturbance known as the dumping syndrome is less common after the Billroth I operation.

Objective of Surgical Treatment of Duodenal Ulcer

The pathophysiology of duodenal ulcer is completely different from that of gastric ulcer, and this difference probably accounts in large measure for the fact that it is much less amenable to surgical therapy. Instead of hypofunction, there is hyperfunction. Whether the hypermotility characteristic of duodenal ulcer is of any surgical consequence or not is unknown. There is good evidence, however, that the hypersecretion of acid gastric juice is of primary importance in the pathogenesis of duodenal ulcer and also bears directly on the hazards of recurrent peptic ulceration following various surgical procedures.

In the last analysis, peptic ulcers are due to peptic digestion of the proteins constituting the gastroduodenal wall. The enzyme pepsin is inactive at a pH higher than 3.5, and is actually destroyed as the pH approaches neutrality. Since pepsin is nearly always present continuously and in abundance, variations in concentrations of hydrochloric acid are much more decisive in the formation of an ulcer. The offensive action of the acid pepsin factor is offset in the normal stomach by (1) neutralization of acid by swallowed food and saliva, secreted mucus, and regurgitated alkaline duodenal fluids; and (2) by the protective action of the mucous coat, and less clearly by "tissue resistance" and certain "pepsin inhibitors" (table 2). The importance of the latter three factors, if any, in the pathogenesis of peptic ulcer is unknown. A relative imbalance, however, between acid secretion and the capacity of the upper portion of the gastrointestinal tract for neutralizing it has been observed under several different experimental conditions to produce regularly typical chronic peptic ulceration. That hypersecretion of acid is a simple and reliable method for achieving this aim is demonstrated in the classic experiment of Hay and his associates[4] in which histamine in beeswax was injected in experimental animals. Similarly, transplantation of the gastric antrum into the colon will result in a pronounced overproduction of the hormone gastrin, which stimulates excessive production of hydrochloric acid in the stomach.[5] Here again chronic peptic ulceration occurs.[6]

When a patient with duodenal ulcer is studied in the fasting state, in the complete absence of any apparent known stimulus, continuous aspiration of the stomach reveals a characteristic excessive secretion of acid gastric juice. This amounts

Table 2.—Homeostatic Mechanisms in the Stomach and Duodenum

OFFENSE	DEFENSE	
HCl ⇌ Pepsin	Chemical	food saliva mucus (3 sources) duodenal content (3 sources) "pepsin inhibitors"
	Mechanical	"mucus barrier"
	"Tissue resistance"	

to about four times that seen in normal persons, and has been noted to be present in about 85 per cent of such patients[7]. Psychiatric evaluation has established that this hypersecretion is closely correlated with mental and emotional activity.[8,9] As further evidence of the nervous origin of the hypersecretion, it is completely abolished by division of the vagus nerves to the stomach.

In duodenal ulcer the stomach itself is histologically normal. A close analogy may be drawn to hyperthyroidism wherein microscopic examination of the thyroid gland reveals no abnormality. In both diseases the actual cause is elsewhere, whereas the therapeutic assault must be local. In hyperthyroidism the function of the thyroid gland must be inhibited by drugs or the histologically normal gland largely destroyed through radiation or surgical ablation. It is interesting to note that just as the thyroid gland is enlarged in hyperthyroidism, the stomach of patients with duodenal ulcer is larger than normal, and literally contains more parietal cells.[10] It is unknown whether this enlargement represents a hyperplasia; attempts to reproduce it experimentally have been unsuccessful.[11]

Evaluation of Surgical Measures in Duodenal Ulcer Therapy

From the physiologist's point of view, surgical therapy of duodenal ulcer should be designed in the light of the old dictum, "no acid, no ulcer." Actually, acid need not be completely abolished, but only reduced to a point where the seemingly normal neutralizing mechanisms can handle it adequately. This reduction may be accomplished by two different approaches, first, by reducing the stimuli to the oversecreting gastric mucosa, or second, by drastically reducing the actual amount of acid-secreting tissue.

There are three phases of gastric secretion: nervous, gastric and intestinal. Of these, the first two are by all odds the most powerful and are also susceptible to surgical attack. The nervous phase of gastric secretion is the phase which is greatly exaggerated in patients with duodenal ulcer (fig. 1). From the point of view of the physiologist, therefore, division of the vagi can be expected to reduce drastically the secretion of hydrochloric acid. Surgical experience has borne this out. This procedure was enthusiastically adopted following its introduction by Dragstedt and Owens[12] in 1943, but there has since been an equally extensive swing of the pendulum in the opposite direction. It is presently being adopted by more and more surgeons with considerably less prejudiced attitudes both pro and con. Contrary to widely held opinion, physiologic study indicates that vagotomy is permanent in about 80 per cent of human subjects upon whom it is performed.[13] Likewise, study in large groups of patients has indicated that properly performed ancillary drainage procedures will completely obviate the motility disturbances following vagotomy.

The second or gastric phase of gastric secretion is mediated by the hormone gastrin, which is liberated by the antral or nonacid-secreting part of the stomach. The antrum constitutes approximately the distal 15 per cent of the stomach, but extends considerably higher on the lesser curvature than on the greater, reaching approximately 40 per cent of the distance from pylorus

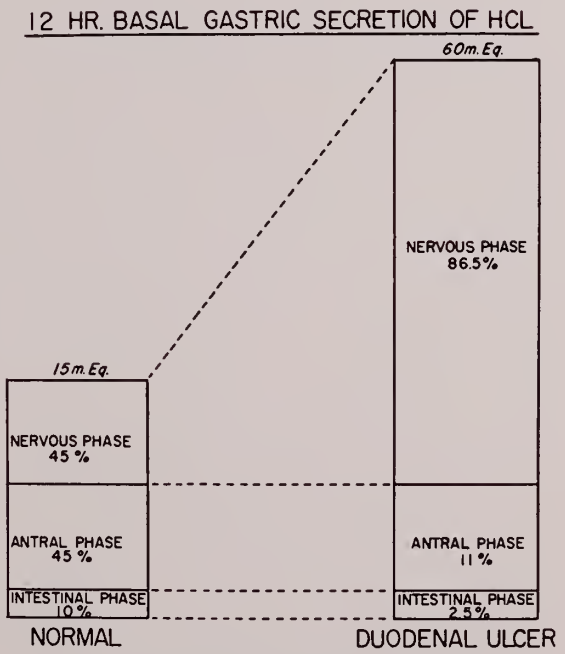


Fig. 1. — Partition of basal gastric secretion in normal persons as contrasted with duodenal ulcer patients.

to cardia. There has been a wave of enthusiasm for resection of the gastric antrum (antrectomy or hemigastrectomy) combined with vagotomy. It is known that the antrum phase may be exaggerated following vagotomy, but study in animals as well as humans indicates that with proper drainage procedures this seldom occurs.[14,15] There is no evidence that the antrum is functioning abnormally in patients with duodenal ulcer. The normal stimulus for antral function, ingested food, reacts the same in patients with duodenal ulcer as in normal persons.[16] A standard test breakfast was given both groups of patients, and the curve of intragastric pH followed for six hours. There was no difference between the two groups. Although antrectomy would reduce secretion in the normal person to about the same extent as would vagotomy, in patients with duodenal ulcer this is a much lesser figure. When the two procedures are combined, therefore, vagotomy is by all odds the more important (fig. 1). Combining the two procedures of vagotomy and gastric resection may be likened somewhat to the man who wears both suspenders and a belt—either one alone should be sufficient.

Relatively short term follow-up studies show impressive results through combining the procedures of vagotomy and antrectomy, with an ulcer recurrence rate which is extremely low indeed.[17] If longer follow-up continues to show such favorable results, it is possible the adding of antrectomy may be worth while despite having to abandon the surgical technical advantages of vagotomy plus drainage procedure (fig. 2).

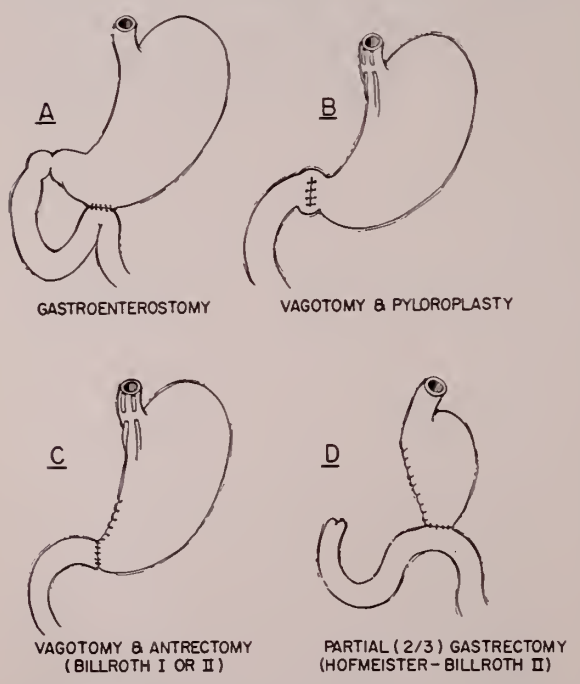


Fig. 2. — Four surgical procedures useful in treating duodenal ulcer.

Distal partial gastrectomy has been by all odds the most commonly used operation for duodenal ulcer in the last 25 years. Although the antrum is removed in this procedure, its major physiologic blow is struck by rather extensive excision of acid-secreting gastric mucosa.* The surgical pros and cons of this procedure will not be dwelt on; certainly it controls peptic ulcer disease in 90 to 95 per cent of cases. The Billroth I gastroduodenal reconstruction is followed much more frequently by recurrent ulceration than is the more usually performed Hofmeister modification of the Billroth II gastrojejunostomy. Postoperative study in such patients shows a much higher incidence of achlorhydria in the latter group, and as time passes after the operation the disparity between the two groups increases.[19] It has been postulated that the perforce reflux of fluid into the gastric stump from the afferent jejunal loop causes a "gastritis" inhibiting production of gastric acid. There is some gastroscopic evidence that this in fact occurs.

The major disadvantage of partial gastrectomy as seen by the physiologist is interference with or a loss of gastric function. Diminution in the digestive function of the stomach does not seem to be important. Loss of the storage function of the stomach, however, is important in a large number of the patients subjected to this operation. For this reason, more extensive removal of the stomach has been abandoned by most surgeons in favor of a relatively conservative 60 per cent to two-thirds removal of the stomach. Using gastric resection for treating duodenal ulcer places the surgeon in an unsatisfactory paradox; the more radical the removal of the stomach the more likely is the peptic ulcer disease to be permanently cured, but also the greater is the physiologic defect created. Related to the loss of storage function, but more specificially the result of loss of the pyloric sphincter mechanism, is the postgastrectomy symptom complex known as the dumping syndrome. The more stomach left the less likely this is to occur and, as pointed out, it is less frequent with the Billroth I anastomosis, probably because of the smaller size of the new gastric exit and the well documented slowe emptying of the gastric stump.

*Wangensteen advocated preservation of the antrum in his segmental type of gastric resection, wherein acid-secreting stomach is resected proximal to the antrum with preservation of gastric continuity.[18]

In the patient with scar tissue obstruction from chronic recurring duodenal ulcer disease, the primary life-threatening pathophysiologic disturbance is obstruction to the outlet of the stomach, that is, high intestinal obstruction. In this often critical situation simple gastroenterostomy may often be just as life-saving a procedure as simple closure of a perforated duodenal ulcer —a maneuver which most surgeons heartily recommend (fig. 2). There is considerable evidence that more extensive surgery in patients with obstruction is fraught with a high incidence of complications relative to resumption of normal gastrointestinal function. This is not surprising since stretch of smooth muscle produces a paralysis or paresis requiring days or weeks for the recovery of normal tone.

Summary

It is pointed out that benign gastric ulcer differs from duodenal ulcer in that there are hypomotility and subnormal secretion of acid gastric juice. Conservative gastric resection (antrectomy) is curative even though the ulcer is not removed. The Billroth I reconstruction is preferred in such cases as being more sound both surgically and physiologically, and the ulcer recurrence rate is inconsequential.

Secondly, control of the hypersecretion of acid gastric juice characteristically associated with duodenal ulcer is singled out as the objective of surgical treatment. This can be accomplished by reducing stimulation through vagotomy and possibly the addition of antrum resection, or by the moderately extensive removal of acid-secreting gastric mucosa through partial gastrectomy. Simple gastroenterostomy can be of life-saving value in obstructing duodenal ulcer.

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Discussion

Dr. Robert F. Dickey, Miami: It has certainly been a pleasure hearing Dr. Woodward's paper. It represents much experience and certainly much thought, based upon physiologic principles. Personally, however, I have not been so fortunate in having such a low malignancy rate of 5 per cent in gastric ulceration. Inasmuch as the majority of gastric ulcers are distal in the stomach and are feasible for resection, and further, in view of the fact that in a few of my cases of benign ulcer the lesion has proved to be malignant, I think they should be resected.

The statement, "no acid, no ulcer," is certainly true. It could be added, however, that there should be no residual acid bathing over an ulcer-prone duodenum. If these statements hold together, the swing again could well be away from the Billroth I operation.

I should like to add four technical points I have followed lately, which have simplified my gastric surgery:

1. Transverse oblique incision, which gives much more exposure and makes the procedure much easier.

2. If one is performing antecolic procedures to remove the omentum, it is easy, quick and safe, and the patient does much better, as he is relieved of an infarcted omentum.

3. On the suggestion of Dr. John T. Kilpatrick, I have used the following procedure on duodenal stumps, particularly if there is a difficult or a "touchy" closure. I put a catheter into the side of the duodenum, approximately 4 or 5 cm. from the end closure, then invaginate the wall around the catheter with three or four sutures, as a Wetzel procedure. This procedure does not interfere with the end closure of the duodenum. Suction is maintained for from two to four days, or until peristalsis is active. The tube which is brought out the right side of the incision is pulled out, and drainage will last only for a few hours. This works on the principle that a duodenum will not blow out if the lumen is kept in a state of negative pressure. This way of handling a damaged duodenum gives a more benign postoperative state of affairs, for both patient and surgeon.

4. For closure of the posterior sheath and peritoneum I use continuous chromic catgut for about three fourths of the incision and then tie. Another catgut suture is used for the remaining one fourth of the incision. This prevents the incision giving way completely posteriorly if a finger or drain has to be put down to the duodenal stump.

Dr. John J. Farrell, Miami: I am happy to have the opportunity to discuss this excellent and timely paper

of Dr. Woodward's. I believe he has performed a real service to this Association in re-emphasizing with physiologic facts the sound clinical viewpoint that duodenal and gastric ulcer are two separate disease entities and should not be classified simultaneously under the common name of peptic ulcer. Also, in describing the basic physiologic facts in the pathogenesis of duodenal ulceration, Dr. Woodward has delineated clearly and concisely the fundamental principles to be employed in the surgical therapy of that disease. There is not and there should not be only one single operation which one utilizes in every patient with duodenal ulcer undergoing surgical therapy. Vagectomy, antrectomy, subtotal resection and occasionally gastroenterostomy, or combinations of these procedures, with a Billroth I or Billroth II anastomosis are all part of a surgical armamentarium and should be employed on an individual basis. The particular procedure must be determined at the operating table, once the anatomy and pathology have been visualized, predicated upon the physiologic background of the individual patient. The preoperative surgical evaluation to determine this physiologic background should include overnight gastric secretion values, the age and body build of the patient, the psychosomatic ramifications, and, not least of all, an estimate of the patient's cooperation or lack thereof in the years subsequent to this surgical convalescence.

Like Dr. Woodward, I, too, like the Billroth I anastomosis and will use it whenever the underlying physiologic pattern of the patient justifies its employment. Certainly it is the anastomosis of choice in resections for benign gastric ulcer. Also, my associates and I have had a considerable number of satisfactory results in selected duodenal ulcers in conjunction with a vagectomy and antrectomy. The dumping syndrome will occur with a Billroth I anastomosis, and its appearance seems to be related to the extent to which the duodenum has been mobilized in the Kocher maneuver: the more mobilization, the greater the incidence of dumping. We have learned from several experiences that the patient should be cautioned against the ingestion of real warm or real cold liquids for two or three months after a gastroduodenostomy since these liquids frequently pass directly into the duodenum. If this occurs, almost immediately the patient will experience nausea and faintness, and occasionally will vomit.

I do not believe the major physiologic blow in the usual 60 per cent gastrectomy is the removal of acid-secreting gastric mucosa. I have been concerned with the fact that following such a resection at least 60 per cent of the parietal cell area of the stomach remains intact and for that reason have swung more and more to the addition of vagectomy in those cases, especially in the younger patient.

I must take issue with Dr. Woodward's views on the management of gastric ulcer. It has not been our experience that competent surgeons and pathologists can differentiate between a benign and a malignant ulcer by direct vision. We are not referring to ulceration in suspicious lesions but to gastric ulceration per se regardless of size. I have seen errors made both ways: benign called malignant and malignant called benign in the hands of excellent and experienced men. In fact, frozen sections have not given 100 per cent accuracy in our hands.

A case at the Jackson Memorial Hospital about two months ago is the most recent proof of this which I have witnessed and adequately demonstrates the dangers in reliance on gross appearance. The patient was admitted in extremis with a four day old severe generalized peritonitis due to a ruptured sigmoid diverticulum. A highly competent senior resident performed an emergency diverting colostomy and in anticipation of a protracted ileus, slipped in a gastrostomy tube. Because of a past history of duodenal ulcer he inspected and palpated the duodenal bulb and the stomach thoroughly. Six days later the patient had a massive, exsanguinating gastric hemorrhage. Another emergency procedure was carried out by another senior resident and an attending surgeon with the first operating surgeon also present. A gastroduodenotomy showed the hemorrhage to be due to a superficial erosion about 4 cm. from the gastrostomy. Because of the pathologic changes visualized and the condition of the patient it was elected to mattress suture the erosion and get out. This measure controlled the hemorrhage, but four days later another serious bleeding episode began. The abdomen was reopened, and a sleeve resection was accomplished with a successful outcome. The opinion of the senior resident, the attending surgeon and the pathologist giving the gross description was that of an acute stress ulcer. The final microscopic diagnosis was a malignant condition.

I think that surgeons must define their reasons for operating upon gastric ulcers. I agree that a large resection with residual imbalances is undesirable for a benign condition. If, however, the operation is performed because of the possibility of malignant disease—and I believe this is a valid reasoning if a rigid medical regimen, preferably in the hospital, has failed to heal the ulcer in three to four weeks - then the ulcer must be removed. Since patients have little use for the omentum postoperatively, we remove it in gastrectomies for duodenal ulcer, as well as gastric ulcer. We believe the resection for gastric ulcer should follow the basic principles of cancer surgery in those instances.

If one is operating upon gastric ulcer thought to be benign as the therapy of choice over medical therapy for the same entity because of the recurrence rate seen with medical therapy, this should be clearly understood. I would, however, caution against leaving the ulcer behind. We have had the experience of seeing a gastric ulcer heal completely on a medical regimen only to find the patient's condition inoperable because of carcinomatosis one year later. At the operating table even a 99 per cent accuracy in gross diagnosis leaving ulcers behind is not justifiable to the one patient in whom the error was made.

DR. DONALD F. MARION, MIAMI: In connection with the reported malignancy in his gastric ulcer group, I should like to ask Dr. Woodward at what time and by what means he found that a given ulcer was malignant. Was it at the time of the original operation or at some subsequent operation because of recurrence? I am curious to know whether it was based on his experience with resection because it appears to me that many persons frequently have a tendency to do poorly after all types of gastric surgery and what has been said is fascinating, but it sounds rather dangerous and I wish he would clarify it.

Also, I should like to comment on his encouraging remarks that in his opinion following the Billroth I procedure or any other procedure that maintains the duodenum as the initial passageway from the stomach, the miserable combination of symptoms grouped together as the dumping syndrome is less likely to occur. I wish he would say another word or two as to incidence. The recently recorded Henry Ford Hospital experience was published in its current bulletin, and after a careful survey of some 2,500 patients with different types of operations for ulcer, it was not possible to say that the incidence of the dumping syndrome was influenced by the type of operation that was performed. My own limited experience here in Miami is the same.

I commend Dr. Woodward for his scholarly paper reiterating the physiological mechanisms that are still under investigation and which are of primary importance in either medical or surgical treatment of this disease.

DR. WOODWARD, closing: I am not surprised at the disagreement with the views I have expressed on the gastric ulcer problem, since they differ from those commonly accepted in surgical circles. I believe, in part, that the traditional view fails to realize that diagnostic procedures have improved so much that the benignity or malignancy of a gastric ulcer can be determined preoperatively in the vast majority of cases. Improvements in x-ray diagnosis alone, with the filming fluoroscope and more recently the image intensifier, add greatly to this means of diagnosis. Gastroscopic technics and instruments have likewise improved and allow also for direct biopsy. In addition, the use of exfoliative cytology can be extremely useful in this differentiation, and this method has

probably not been pursued to the extreme of its ultimate usefulness.

The success of such a program also depends on close working arrangements between medical gastroenterology and surgery, a circumstance obtaining at the Los Angeles Veterans Administration Hospital where the present study was made.

Fortunately, the majority of gastric ulcers occur on the lesser curvature in the distal part of the stomach and can be treated adequately by a relatively conservative distal partial gastrectomy. I believe that a subtotal gastrectomy for cancer is a completely different procedure from that used for benign gastric ulcer. The former carries an operative mortality of 5 to 9 per cent, whereas a simple conservative gastrectomy for benign ulcers should carry a mortality of less than 1 per cent. For patients who probably have benign disease on the basis of all evidence at hand, I believe it is unwarranted to subject them to this additional risk. If any doubt remains at the time of laparotomy, clearcut pathologic evidence can readily be obtained by appropriate biopsy, even to the point of locally excising the ulcer.

Kartagener's Syndrome in Identical Male Twins and a Female Sibling

Report of Cases, With Comments on Pathology and Familial Manifestations

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Kartagener's syndrome, a triad consisting of situs inversus with bronchiectasis and paranasal sinusitis, has previously been recorded in multiple siblings in at least seven family groups.[1-7] This report is the first description of the triad in clinically identical twins; in addition to the male twins, a younger female sibling was similarly afflicted. Siewert,[8] in 1904, was the first to describe bronchiectasis accompanying situs inversus, and the second case was a necropsy report by Oeri[9] in 1909. The first report on multiple siblings was that of Gunther,[1] in 1923, who described the occurrence in two sisters among four siblings; a parent, five aunts and an uncle were all free of the disease. Kartagener and Horlacher[2] described two sisters with the triad, and a brother normal except for epilepsy. Lopez[3] reported the cases of two brothers and a sister. Bergstrom, Cook, Scannell and Berenberg[4] reported the cases of two brothers with Kartagener's triad, one of whom also had hypospadias and the other congenital heart disease with cyanosis; but, as a new finding, two out of four additional siblings, the lone sister and another brother, had bronchiectasis and sinusitis without situs inversus. Kaye and Meyer[5] reported on siblings, a female aged 22 years and a male aged 20 years, the former patient presenting, in addition, an anomalous left subclavian artery.

Hebel[6] described two sisters with Kartagener's syndrome, one of whom died following a spontaneous pneumothorax secondary to chronic pneumonia; the second sister, in addition to the classical triad, exhibited also clubbing of the fingers and a kyphoscoliosis. Another sister had sinusitis, bronchiectasis, kyphoscoliosis and facial asymmetry, but no situs inversus. In all three of these patients the frontal sinuses were absent. In addition, in this family there was another sister who had the deformity of the dorsal spine along with asthmatic bronchitis. A fifth sister and a brother were entirely normal. An interesting additional finding in this family was the occurrence, as in three of the sisters, of a severe scoliosis in an aunt, two uncles, and the grandmother, all on the maternal side. The father showed the clinical findings of a chronic sinusitis. Dickey[7] reported the case of a white girl aged 10 years, and of her brother, aged 14, both much improved following left middle lobe resection.

By 1947, 80 cases of Kartagener's syndrome had been collected in the literature, but in a report of 1955, Taiana, Villegas and Schieppati[10] listed 104 cases; several additional cases, exclusive of our three, have since been reported. The

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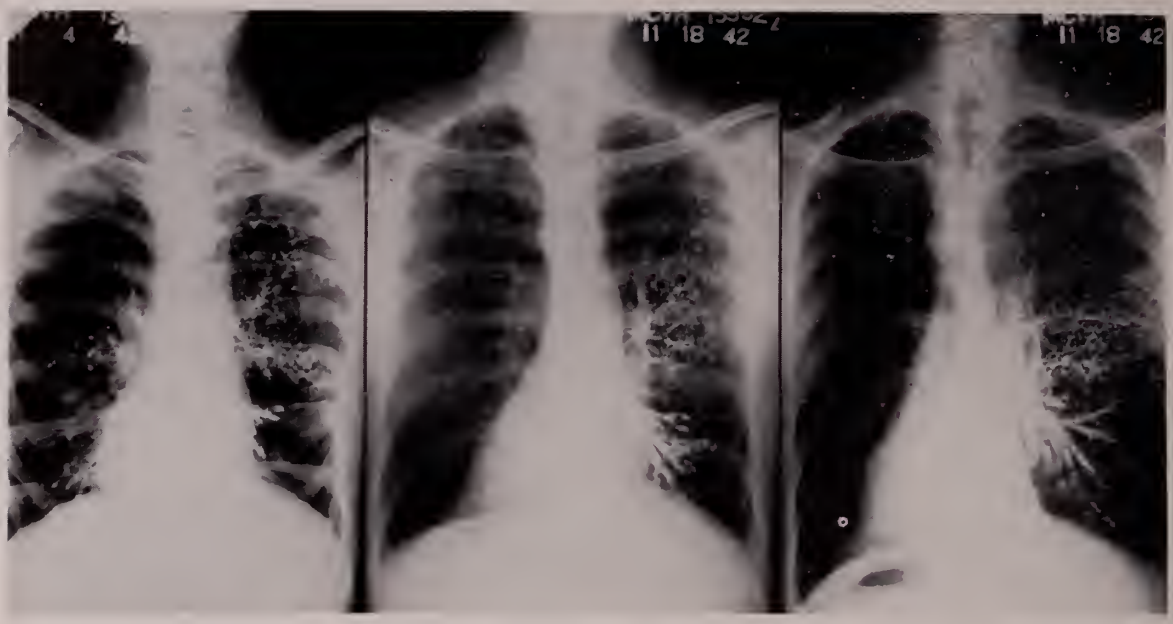


Fig. 1. — Posteroanterior bronchogram of sister and male twins showing saccular and fusiform dilatation of many of the opacified bronchi.

subject is a timely one because an awareness of the association of situs inversus with bronchiectasis, the chief clinical feature of the syndrome, might lead to an early recognition of a potentially dangerous condition which can now be benefited by the advances of thoracic surgery and medical therapy. Alertness, particularly on the part of the pediatrician, is most important, since in 90 per cent of cases in which the age of onset of symptoms was given, it was before the age of 14; in fact, a recent report by Nichamin[11] recorded the diagnosis in a newborn infant 33 hours old. Our records on the family group here reported commence in 1939, and include information culled by a follow-up questionnaire of 1955.

Report of Cases

Case 1.—A 31 year old, fairly well developed and nourished, white, married farmer was admitted to the Medical College of Virginia Hospital on March 30, 1939, because of abdominal cramps and localization of pain in the left lower quadrant of the abdomen, which had become complicated by a recurring infection of the upper part of the respiratory tract. Relevant history included long-standing bronchial asthma and a productive cough with no blood streaking.

The family history disclosed that the father had had diabetes, and suffered a terminal heart attack at the age of 61, in 1935; he had four sisters with diabetes. The mother was alive and well. None complained of respiratory symptoms. The patient related that he, as well as an identical twin, and also a younger sister had complete transposition of viscera, and that all exhibited varied respiratory symptoms. In addition, there were four other siblings, two brothers and two sisters, who were all reported to be in good health. Neither of the afflicted twins had offspring, and the sister was unmarried.

Clinical examination and roentgenograms of the chest confirmed the presence of situs inversus. Lobar pneumonia was suggested toward the left lower lung field, the sputum showing Pneumococcus type II. In addition to abdominal spasm and tenderness, a large, palpable mass was present in the left lower quadrant of the abdomen. The white blood cell count was 24,400.

On March 21, under local anesthesia, supplemented by nitrous oxide and oxygen, a periappendiceal abscess was drained through a left lower quadrant incision, and the appendix was incompletely removed. A febrile, turbulent postoperative period ensued, which necessitated inhalation therapy and massive doses of sulfonamides; the asthmatic condition required specific medication, and the anoxia was at one time complicated by cyanosis resulting from sulfapyridine. The patient was discharged on April 8.

The surgical episode was elaborated upon to underscore the fact that Kartagener's syndrome presents an ideal background for complications and generally increased morbidity. In 1955, the patient stated that overt symptoms of rhinitis and of a dry oropharynx had first appeared some time subsequent to the hospitalization reported, but that the long-standing asthma had worsened during the past 10 years, and that he could definitely relate the symtoms to food allergy and emotional strain; he had become dyspneic, and his cough was still severe and productive.

The bronchogram and sinus roentgenograms depicted (figs. 1b, 2b and 3b) were made several years later. The roentgenograms of the twin brother (figs. 1c, 2c and 3c) and of the sister (figs. 1a, 2a and 3a) might well, for the sake of convenience, be appraised at the same time. It can be noted that the gastric gas bubble was on the right side in all three patients. Selective bronchography had been done, and the left lower lobe showed bronchiectatic changes, with additional areas also involved, in all three cases. In the case of the sinus roentgenograms, all showed pronounced maxillary sinusitis. The female showed undeveloped frontal sinuses and much clouding of the ethmoid and sphenoid sinuses. There was a tendency toward rudimentary frontal sinuses, particularly in one of the males, with slight frontoethmoid sinusitis, and with mild clouding of the sphenoid sinuses in only one of the twins.

Case 2.—A married, fairly well developed, white farmer was 34 years old when the bronchogram and sinus roentgenograms, dated Nov. 18, 1942, were made (figs. 1c, 2c and 3c). His past history included bronchial

asthma with seasonal variations, and a cough since childhood; he had had repeated pneumonic infections. The cough was productive of one cupful of secretion daily, with no blood streaking. He had had pertussis in childhood. He was a nonsmoker. There was poor hearing in the left ear, aggravated by infections of the upper portion of the respiratory tract; the voice was deep and husky.

The patient was admitted to the Medical College of Virginia Hospital on April 11, 1944, for observation for a possible appendicitis as he had pain in the right lower quadrant of the abdomen radiating to the left. In addition to the abdominal tenderness, the physical examination at the time revealed coarse inspiratory and expiratory rales, as well as sibilant and sonorous rales throughout the emphysematous thorax. Upon the prompt subsidence of abdominal symptoms, bronchoscopy was performed on April 14, at which time considerable amounts of bilateral secretions were aspirated, followed by insufflation of a mixture of sulfanilamide and sulfathiazole powder.

On Sept. 1, 1947, the patient, now aged 40, was readmitted to the Medical College of Virginia Hospital because of previous chills, diarrhea and cramping abdominal pain; there were also fever and leukocytosis, the white blood cell count ranging between 16,000 and 29,400. Roentgenograms of the chest at this time suggested bronchiectasis but no gross pneumonia. The abdomen showed some fulness of the left rectus, with spasm and tenderness and some rebound in the left lower quadrant; on the left side the pelvis was tender on rectal examination. There was no distention or abdominal gas sound. Because of the increasing leukocytosis, and because bizarre findings were to be expected in situs inversus (note the case of ruptured appendix in a twin brother several years before), a laparotomy was performed, under spinal anesthesia. The pathologic report was that of pyoappendix, with mucosa intact, and with no cellular infiltration. Except for the frequent requirement of aminophylline and epinephrine to control the asthma, the postoperative course was uneventful until the third day, when a rise in temperature occurred, along with other physical findings of atelectasis at the left base; at this time, fetor of the breath also developed. Recovery followed institution of appropriate therapeutic measures, which included inhalation of carbon dioxide, deep breathing exercises, aerosol and parenteral penicillin, and additional chemotherapy.

In a follow-up note of May 1955, the patient stated that nasal symptoms had persisted, and that the long-standing asthma and cough had greatly worsened during the last five to six years; that the increasing dyspnea had recently forced him to stop working, and that he was currently receiving treatments at an allergy clinic.

Case 3.—A 32 year old, single, white woman was admitted to the Medical College of Virginia Hospital on Aug. 25, 1942, for proposed sinus surgery. The history was one of increasing asthma of long standing, aggravated by food allergy and smoke fumes, nasal obstruction and anosmia, a productive, foul cough, and occasional hemoptysis. Other symptoms included headache, vertigo, occasional hoarseness, and impaired hearing in the left ear. The past history included influenza in 1918, several bouts of pneumonia, the most recent one in 1924, and tularemia in the right lung in 1939. In 1924, the patient spent 10 weeks in a tuberculosis sanitorium, but no active pulmonary lesions were discovered. She had had a tonsillectomy in 1922, and an appendectomy in 1931. She had never married, and had never been able to work.

Prior to this hospital admission, the patient had been examined at length in the outpatient allergy and nose and throat clinics, and the eosinophil count had at one time been 12 per cent in the blood and 20 per cent in a nasal smear. The previously described sinus roentgenograms of Aug. 13, 1942 (fig. 3a) were part of this study, and a routine roentgenogram of the chest on August 20 of that year suggested an abscess of the lung 3 cm, in size with fluid level in the right lower lobe, between the ninth and tenth ribs posteriorly; in addition, bronchiectatic changes were also suspected.

On physical examination, the sinuses transilluminated poorly, and inspection revealed pale mucosa of the nose with polypoid degeneration of the middle turbinate, and polyps and pus in the middle meatus. There was pain in the maxillary antral region. The left tympanic membrane showed old perforations with slight retraction. There were pharyngeal granulations, and slight cervical lymphadenopathy. The patient was orthopneic, and in the emphysematous chest there were expiratory rales. The upper ribs were prominent, and the point of maximal impulse was not felt. There was an incisional hernia at the right lower quadrant, and the abdominal scar had been extended to the left. There was no evidence of hypertrophic pulmonary osteoarthropathy. The white blood cell count was 18,350, with 80 per cent neutrophils. The sputum was negative for acid-fast bacilli, spirochetes and fusiform bacteria; there were gram-negative bacilli resembling

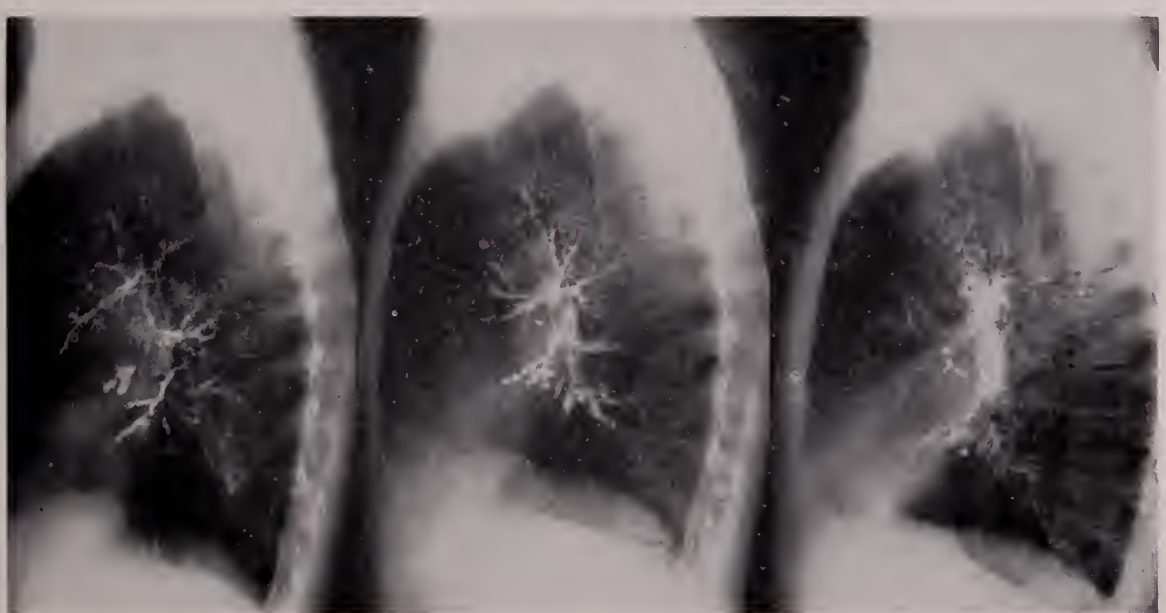


Fig. 2. — Left lateral views of bronchogram on the three siblings reported, showing evidence of bronchiectasis.

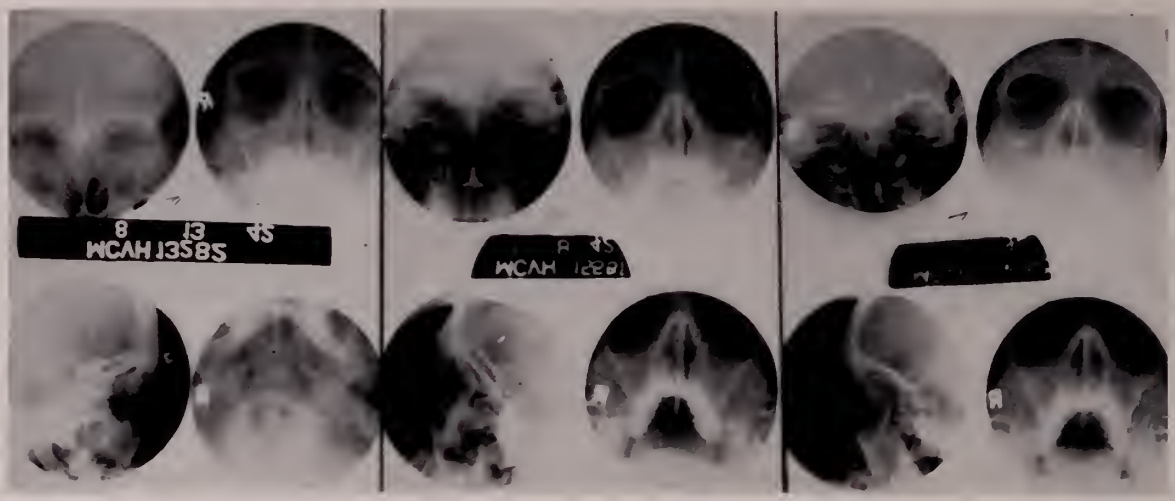


Fig. 3. — Multiple views of paranasal sinuses show clouding of maxillary antrums and other sinus groups; note absence of, or rudimentary, frontal sinuses.

Friedländer's bacillus. The serologic examination gave negative results, and urinalysis was not remarkable.

An antrotomy and ethmoidectomy on the right side were performed at this time, and the following month, the same procedures were carried out on the left side. The curettings were described as benign mucosal polyps, with cystic mucosal glands; there was a round cell infiltration, as well as the presence of eosinophils and other polymorphonuclear cells. Recovery was uneventful, and the patient was discharged with some decrease in postnasal secretion. As before, the chest condition required continuing observation; a bronchogram, made on November 4 (figs. 1a and 2a) demonstrated the bronchial dilatation. Because of a postural, productive cough, the patient was readmitted to the hospital on April 18, 1943, for a bronchoscopic examination. This procedure revealed copious pus bilaterally, which was aspirated, and sulfonamide powder insufflated; slight symptomatic improvement ensued.

The 1955 follow-up questionnaire showed persisting asthma, with shortness of breath on occasion; the patient had had no severe head colds in the past 17 years, but there was a thick mucous discharge at all times, and a cough productive of yellow mucus. The menopause occurred in May 1951, and this coincided with the end of blood streaking in the bronchial secretions, as well as with some general improvement, except for shortness of breath.

Incidence and Pathogenesis

Surveys[12,15] show a higher incidence of bronchiectasis with situs inversus, the figures ranging from 12 to 23 per cent as against an incidence of 0.3 to 0.5 per cent in a general hospital and clinical population. Gunther[1] and more recent authors have estimated that situs inversus occurs in about one out of every 8,000 persons. The genetic implications [13,15,16] will be alluded to briefly. The majority of patients with situs inversus do not have an associated vulnerability of the respiratory system, and represent pure genetic mutants; the other group is apparently subject to environmental, possibly genetic influences acting prior to or during the earliest stages of cell division.

Of interest along these lines is the fact that Torgersen[15] reported a 25 per cent incidence of bronchiectasis and nasal polyposis among siblings of persons with Kartagener's syndrome, but found only a rare sporadic case of polyposis, and no bronchiectasis, in siblings of patients with situs inversus alone. This concept tends to be borne out by the fact that in spite of multiple occurrence of Kartagener's syndrome in several families, in only rare instance[6,17] has there been any suggestion of bronchial disease in the parents of children with the triad, though the kyphoscoliosis which occurred in two generations in the family reported by Hebel[6] may represent a more distantly related genetic stigma.

Various theories have been proposed to explain the bronchiectasis accompanying visceral transposition, including some based on structural defects, or on the mechanical influence of dextrocardia, or on abnormalities of the respiratory epithelium. Of interest in this last respect is Olsen's report,[12] in which all patients with dextrocardia demonstrating bronchiectasis, with or without sinusitis, were upon further investigation found to have a total situs inversus. More recently, a case of bronchiectasis with beneficial resection in a patient with sinusitis and dextrocardia, without additional visceral transposition, has been included among a series of cases of classical Kartagener's syndrome,[7] and the statement made that the classic criteria should be modified to include this type of case.

Additional congenital anomalies accompanying dextrocardia or situs inversus are not uncommon. Olsen[12] stated that in 11 out of 83 patients with dextrocardia there were additional anomalies, including congenital heart disease, hydrocephalus, imperforate anus, cleft palate, flail thumb and accessory digits. Cockayne[16] found congenital heart disease in five out of 55 unselected cases of situs

inversus; and in another larger group there were 40 cases of congenital heart disease associated with transposition, 15 cases of which were examples of tetralogy of Fallot. In general, however, it would appear that classical Kartagener's syndrome is less frequently accompanied by additional serious congenital defects. These include some of the anomalies listed by Olsen,[12] as well as spina bifida, exostoses, and also in one case a vascular anomaly of the eyegrounds (Schletter-Klenk), as cited by Hebel.[6]

Clinical Considerations

Though the presence of severe, long-standing bronchial infection is characteristic of the syndrome, the symptoms often being initiated by a pneumonia or pertussis, and traceable to infancy in half the cases, the degree of pulmonary involvement is variable. Actually, in only about 20 per cent of all cases reported is there clearcut roentgen evidence of bronchiectasis.[4] Similarly, involvement of the paranasal sinuses, which occurs in about 55 to 70 per cent of the cases, varies from no apparent change to severe sinusitis and nasal polyposis; hypoplasia of sinuses predominates, the frontal sinuses being small or absent in 50 per cent of the cases.[18] The simultaneous localization of infection in the upper and lower portions of the respiratory tract in a newborn infant would negate a purely causal-sequential relationship, pointing toward "a coordinated constitutional factor,"[18] which might well be operating in all cases of congenital bronchiectasis. Of distinct interest in this respect, in relation to the cases of identical twins we are reporting, are the cases of bronchiectasis and congenital absence of frontal sinuses in the identical twins described by Pastore and Olsen,[19] and in the similar two familial instances (Sayé L.; Meyer, H. E.) cited by these authors.

Prophylaxis and Therapy

As has been pointed out, the early recognition of Kartagener's syndrome is today more than a matter of academic interest; the symptoms are not severe in every case, but certainly the prolonged morbidity of the three patients in the cases we are reporting, and the stormy postoperative course in two of them, are adequate evidence of this fact. The institution of prophylactic therapy, or prompt administration of wide spectrum antibiotics in the presence of infection, might decrease the frequency of bronchiectasis in the clinical syndrome. It would appear that in general, if indicated and feasible, extirpation of frankly bronchiectatic areas is the treatment of choice, even in the younger age group;[20] and that medical treatment plays an important role primarily in the preparation of patients for surgery, but remains an essentially palliative measure that might not prevent progression or other complications. Treatment of the sinusitis is indicated, although it is usually not nearly so successful as that of bronchiectasis.

A thorough study and appropriate therapy from the point of view of allergy are also indicated. Nasal polyposis is of course a typical late manifestation of allergic rhinitis; also, the incidence of asthmatic bronchitis, as in our patients, is high. A parallel is likely present between the distinct amelioration in allergic symptoms which our female patient reported experiencing following the cessation of her menses, and the dramatic response to therapeutically administered steroids.

While the recognition of even uncomplicated situs inversus may be of considerable importance in medical diagnosis and surgical technic, because of such factors as bizarre symptoms and misplaced incisions, it is in those cases with concomitant respiratory disease that the attending physician should be alerted to the easily induced atelectasis, infection, hypoxia and other sequelae. Persons with situs inversus, particularly those with concomitant paranasal sinus infection, should be thoroughly investigated for bronchiectasis; and the families of patients with Kartagener's syndrome should be screened to determine the presence or absence of similar abnormalities.[21]

Summary

The occurrence of Kartagener's syndrome (situs inversus, bronchiectasis and sinusitis) is here reported for the first time in clinically identical twins; in addition to the male twins, a younger sister exhibited the classical triad, while the other four siblings and other members of this family were normal. Seven other instances of family groups presenting multiple siblings with Kartagener's syndrome have been reported in the literature. Kartagener's syndrome is briefly discussed in some of its pathologic and clinical aspects. The seriousness primarily of the bronchiectasis is stressed, and the importance of its early recognition among patients with visceral transposition is emphasized. The factor of familial occurrence is pointed out.

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Research in Our Health Departments

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A recent health bulletin includes an eye-catching quotation entitled "Research—Or Stay Behind!" It states this conclusion of Dr. William C. Menninger, "I don't think it makes any difference whether we're in the oil business, the airplane business or trying to discover Salk vaccine; we don't get ahead if we don't do research."[1] Industry is convinced; it expends some $7.3 billion per year for research and development.[2] An exhibitor at this convention commented in discussion that the pharmaceutic and biologic industries commonly budget about 5 per cent of gross for research and consider this an essential investment. Progress through research is an outstanding characteristic of our times, but the status of research in our state and local health departments is not in accord with this general picture. In the review "Medical Research — A Mid Century Survey," it is noted, "In most state and city health departments research is still the exception."[3] This contrast is thought-provoking. It demands that we examine critically the past and present scope, and consider the possible early expansion, of research in our health departments.

Medical research in general is conducted "in the laboratory, in the clinic and in the field." "In the laboratory" attention is centered on the cell, the ingredient, and on basic processes. "In the clinic" attention is on the individual as an independent entity. In clinical studies there is concern with cells, body fluids and social influences, but the focus is on the single individual. "In the field" the focus is on the community. This is the characteristic feature of research in health departments. It studies individuals as members of a community; its focus is on the health and welfare of population groups. This is the type of research to which attention is directed in this discussion.

Public Health Research—in the Past

The pressing need for the control of communicable diseases, and particularly of epidemic outbreaks, gave birth to public health. These were urgent community problems. The need for a better understanding of causes, modes of spread and means of prevention was obvious. With the occurrence of an unusual number of cases, the immediate action of the health officer was to "investigate the epidemic." Even in sporadic infections, the responsibility of the epidemiologist as stated in the every day language of the health department was to "investigate the case." Whether single or multiple illnesses, a major concern was the significance of the infection to the con-

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tacts and to the community. Thus, in its beginning and throughout its progress in the control of communicable diseases, public health approached its problems in the spirit of investigation. Its attention was centered on the welfare of the community, and its major investigative procedure was field studies.

The historical importance of this method of approach may be illustrated by reference to classical studies such as that of Snow in his studies of cholera or more recently the investigations of tularemia in this country by Francis, by the work of many health departments on commonly occurring diseases such as typhoid fever, diphtheria and tuberculosis, down to the coordinated field studies to evaluate the efficacy of polio vaccine. That which we now call public health research has a proud record of past accomplishments.

Public Health Research—Today

Recent decades have seen a transformation in organized public health in this country. The communicable diseases have declined from their place of first importance as a cause of death. The high significance of cardiovascular diseases, neoplasms, mental illness and other chronic diseases to the health and welfare of the community has become increasingly evident. Environmental problems, once limited to food, water and sewage, now extend to air pollution, insect control, housing and radiation. There is an awareness that there is need for an effective program for the building of optimal health in the aged—as also in those of younger years—for which at present there is no program of proved worth. The need for organized action to assure that indigent and medically indigent persons receive appropriate medical care and the administrative role of health departments in attaining this end are recognized. Here are problems as challenging as any ever offered by the communicable diseases and ones equally in need of research, but today the spirit of investigation is not clearly evident in the public health approach to these new problems.

As in many other fields of activity, there has been in recent years a more active participation of federal agencies in the development of state and local public health programs. Prior to 1935, state health departments looked to what is now the National Institutes of Health for supportive assistance in the study and control of communicable diseases. Their cooperation in field studies was a common and stimulating experience. With the great expansion of the Public Health Service in the past two decades there has been a separation of those concerned with service to the states and those in research. To an increasing extent those visiting state and local health departments came from the Bureau of States Services of the Public Health Service, or from the Children's Bureau. These consultants, emphasizing that the funds with which they were concerned were for the provision of health services, tended to divert attention from, rather than direct it to, research.

Today, leadership in medical research to a large extent comes from the National Institutes of Health. In little more than a decade there has been developed in Bethesda, Md., this country's and probably the world's outstanding laboratory and clinical center for medical research. Simultaneously, a research grants program was evolved which has lead to a rapid expansion in medical research. In 1957 there were 6,186 National Institutes of Health grants for a total amount of $80,906,075.[4] In the first decade of the development of this program, however, the expansion has been almost exclusively in laboratory and clinical research. Grants were provided predominantly to universities, particularly medical schools, to hospitals and to research institutes. The members of the advisory councils and study sections, as might be expected, were drawn almost entirely from the institutions in which research was being conducted. Thus while the Institutes gave leadership in laboratory and clinical research, they failed to provide any comparable stimulus to the development of research in the public health environment. While state and local health departments were being encouraged and assisted in their service programs, there were few, if any, contacts with Public Health Service personnel concerned with research. The spirit of investigation, so prominent in public health of earlier decades, has not thrived in this environment.

Despite a lack of active encouragement of community-centered research, studies have been carried forward in some areas. Moreover, there has been an indication in recent months of a new interest in public health research on the part of federal agencies and in several of the state and local health departments.

Looking to the Future

The recent rapid strides in medical research in the United States have resulted from effective joint action by the National Institutes of Health and a variety of institutions scattered throughout the land. For public health to share appropri-

ately in this research program, we, in health departments, must understand what may be expected, or hoped for, from the National Institutes of Health and we must consider critically our own responsibilities.

The Director of the National Institutes of Health, Dr. James Shannon, commented recently, "As the focus of modern medicine and the health sciences turns toward the chronic diseases, research workers must be prepared to tackle these problems simultaneously in the clinic, in the laboratory and in the field."[5] It is appropriate to expect that the Institutes will seek to develop and maintain a reasonable balance in the investigations in these three areas. An objective evaluation of the present program leads clearly to the conclusion that to date the emphasis has been almost exclusively on laboratory and clinical research.

Training programs and fellowships have been used effectively to increase the supply of qualified investigators. It is reasonable to hope that the same consideration will be given to the training for research in the field as is being given now to the training of laboratory investigators. It should be acknowledged in planning that training for community-centered research calls for a distinctive type of experience. It is reasonable to hope that, in the future, health departments in cooperation with universities, or alone, may provide desirable opportunities for training in public health research, and that this development may be fostered through provision of a fair proportion of National Institutes of Health training grants and fellowships to health departments.

During their service on study sections, councils and other committees, many from universities, medical schools, hospitals and research institutes have become intimately familiar with the program of the National Institutes of Health. This opportunity has been afforded to very few from health departments. With greater attention to the development of public health research, it is hoped that the voice of public health will be heard more distinctly in appropriate advisory committees of the Institutes.

Though the future of public health research can be modified to a degree by the National Institutes of Health, the nature of its development will be determined largely by those of us serving in state and local health departments.

First, the distinctive objectives, any unique methods and the true importance of research in health departments must be fully appreciated by public health administrators. The place of field studies in the investigation of communicable diseases is recognized; that a similar approach has a place of comparable importance in chronic diseases is not generally recognized. The recent observations on differences in the occurrence of lung cancer and certain cardiovascular diseases in cigarette smokers and nonsmokers has directed attention to the promise of this investigative procedure. Relatively basic information may be expected from a variety of studies of individuals in their natural environment. The public health worker should be expected to provide leadership in such epidemiologic and other field studies just as the clinician takes the leadership in clinical studies.

Methodological research has a different objective. Comparative studies of the relative efficacy of therapeutic procedures are contributing to the improvement of the practice of curative medicine; in a similar manner we in public health need well designed methodological studies to advance the practice of our specialty. An added unique opportunity in research is open to health departments. It may serve as the collecting center for significant observations by practitioners. This project is being carried out through cancer registers, and it has been most useful in assembling observations on rarer clinical entities. There is the possibility here of encouraging the research talent of interested practitioners. Thus health departments have many opportunities for productive research of varying types.

With an appreciation of possibilities, the public health administrator must decide whether to include research as a part of his program. If community-centered research is to thrive, it must be accepted as an essential part of the activities of our health departments.

When it is so accepted, there must be a budgetary planning for research. Industry recognizes that it cannot afford not to invest in research. Should public health follow the leadership of industry and allocate some 5 per cent of its budget for research, program development and evaluation? If $1 in each $20 were so used, is it probable that the remaining $19 would provide more value in service than the $20 without research? This is a reasonable assumption though difficult to prove or disprove. When research is accepted as an essential part of the activity of our health departments, and when it is provided a reasonable basic support, then and only then is it appropriate to

begin to think of supplementary support through research grants.

At that time the procedures through which grants may be obtained from the National Institutes of Health will need to be understood. Health departments accustomed to categorical grants from the Children's Bureau and the Public Health Service have not always appreciated that research grants, also from the Public Health Service, cannot be obtained in the same manner. The competitive basis for the allocation of research grants is not alone a successfully operating program, but it is one prescribed by law.

If public health is to compete successfully with universities and other institutions for research funds, it must be able to attract and retain personnel equal in training and ability to those in senior positions in medical schools, hospitals and research institutions. A greater flexibility in salary provisions probably will be needed to enable Health Departments to attract these essential persons of high ability.

The productivity of research, as of any service program, will be determined by the nature of the planning. An appropriate organization for research within the state and county health departments will need to be evolved. Specific studies must be planned in detail. Success in competing for research grants is related not alone to the quality of the plans, but also to a convincing statement of such plans.

Thus if research in our health departments is to thrive, its multiple objectives, its diverse methods and its high importance must be clearly appreciated. Its acceptance as an essential part of the activities of state and local health departments will be indicated by appropriate budgetary support. With effective planning, including staffing for research, it may be anticipated that a higher proportion of the research grant funds distributed by the National Institutes of Health will become available for public health research.

In conclusion, it can be emphasized that the Florida State Board of Health and the larger county health departments have accepted research as an essential part of their activities and are being guided by the conclusion, "We don't get ahead if we don't do research." It is believed that the advances in public health in the years ahead will be due in part to the research programs now being initiated in our state and local health departments.

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ABSTRACTS

The Emergency Intravenous Pyelogram. By Benedict R. Harrow, M.D. South. M. J. 51:682-688 (June) 1958.

The general surgeon, the general practitioner and the internist will find this discussion of the use of the intravenous pyelogram in the differential diagnosis of acute abdominal disease of particular interest. The author presents eight illustrative cases to show the important information that can be gained by this means in an occasional patient with acute inexplicable abdominal disease. He observes in summary: Retrocecal appendicitis and right-sided renal colic may present an identical clinical picture. An excretory urogram without preparation will usually solve the problem, leading to no undue delay in removing an inflamed appendix or preventing an unnecessary appendectomy. The emergency intravenous pyelogram may also be useful for diagnosis in ruptured aortic aneurysms, renal trauma, hydrops of the gallbladder, intermittent hydronephrosis, intermittent caliectasis and in unmasking a narcotic addict. If tolerated by the patient, compression should be used in all such cases for better filling of the upper portion of the urinary tract.

Inguinal and Umbilical Hernias in Infancy and Childhood: CONTRAST IN MANAGEMENT. By Frank Turner Kurzweg, M.D. South. M. J. 51:961-965 (Aug.) 1958.

Two types of hernia of the anterior abdominal wall, inguinal and umbilical, occur rather frequently in infancy and childhood. The difference in prognosis and the possibilities of complications make the management of these two kinds of hernia radically different. A series of cases is here reported in which 100 patients 12 years of age or under were treated surgically for inguinal hernias and seven patients of the same age group were operated upon for repair of an umbilical hernia during a 12 month period. The change from nonoperative to operative treatment in the management of inguinal hernia is discussed. The reason for the change is the high incidence of complications from inguinal hernia in infants and children. Mention is made of the type of inguinal hernia found, its association with hydrocele and cryptorchism and the embryologic defect in its development. In contrast, the management of umbilical hernia in infancy and childhood is usually watchful waiting. The defect at the umbilicus will close spontaneously in most cases.

Carcinoma of the Colon Under the Age of 40. By Joseph A. Ezzo, M.D., James F. Sullivan, M.D., and Robert E. Mack, M.D. Ann. Int. Med. 49:321-325 (Aug.) 1958.

Noting that carcinoma of the colon is one of the commonest malignant growths occurring in young adults and finding no published report concerning this disease in the younger age groups, the authors reviewed the cases of colonic carcinoma at the St. Louis University Hospitals in order to investigate their suspicion that the disease might be a more malignant process in young adults. In their series of 32 cases, the five year survival rate was less than 21 per cent at best. This rate led them to conclude that carcinoma of the colon is a formidable disease which apparently has an accelerated course in patients under 40 years of age. The duration of symptoms prior to operation did not seem to be an important factor in patient survival. The excellent prognosis in two cases of malignant polyp found by routine sigmoidoscopy contrasted sharply with the poor prognosis when patients experienced symptoms, regardless of the duration of the disease.

Cysticercosis: REPORT OF TWO CASES—ONE WITH GIANT VESICAL CALCULUS. By Arthur J. Butt, M.D., and J. J. Baehr, M.D. South. M. J. 51:1190-1192 (Sept.) 1958.

Human cysticercosis is uncommon in the United States in contrast to its prevalence in Asia, Europe, South America and Mexico. It is becoming more frequently recognized and reported of late, the authors point out, but up to 1954 only 42 cases had been reported in residents or citizens of this country. Two cases of human cysticercosis in the United States are here added to the growing list of reported cases. Urinary tract calculi were present as coincidental findings in both cases, in one of which there was a giant vesical calculus.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

eighty-fifth

annual convention

may 2-6, 1959

bal harbour



Program of Eighty-Fifth Annual Convention

General Information

Convention Headquarters

Headquarters are the Americana Hotel where most activities are scheduled. Many of the specialty societies, approved by the Board of Governors, are holding their meetings in the same hotel concurrently.

Registration

The Registration Desk is located in the Exhibit Hall and will be open Sunday, Monday and Tuesday 8:30 a.m. to 5:30 p.m. and Wednesday 8:30 a.m. to 12:30 p.m. Each member is required to register and obtain an identification badge before attending any sessions. Guests and ladies are also required to register. There is no fee. Printed programs are available at the Desk.

Members are urged to present their 1959 membership cards from which both their registration card and badge can be stamped by machine.

President's Reception

The President's Reception will be held on the Starlite Patio from 6:15 to 7:15 Monday evening. Tickets are $3.00 per person available at the Association's Registration Desk in the Exhibit Hall.

Blue Shield

The annual meeting of Blue Shield is being held at 4:00 p.m. Monday in the Grand Ballroom. There will be no conflicting meetings. All delegates seated at the First Session of the House of Delegates on Sunday afternoon are urged to attend. Delegates are Active Members of Blue Shield.

Technical Exhibits

The Technical Exhibits are located in the Exhibit Hall of the Americana Hotel and may be visited Sunday, Monday and Tuesday from 8:30 to 5:30 and on Wednesday from 8:30 to 12:30. The exhibits are an important part of the Annual Convention and each physician will be well repaid by spending some time inspecting them.

Anglers

Physicians desiring to arrange a fishing trip should contact Dr. Robert F. Dickey, 309 Ingraham Building, Miami 32, telephone FR 4-6324, chairman of the Anglers Committee for the Annual Convention, or a member of his committee, Dr. John T. Kilpatrick and Dr. Thomas S. Gowin.

Florida Medical Committee For Better Government

The annual meeting and election of officers for the Florida Medical Committee for Better Government is scheduled for Sunday beginning at 8:00 p.m., Rooms 204-205, Americana Hotel.

Golf

The Golf Tournament will be held at the LaGorce Country Club, May 4-5. Dr. Rene A. Torrado of North Miami is chairman of the Golf Committee. Assisting him are Drs. John H. Tanous and Lester A. Russin. Members are urged to bring their own equipment. Green fee—$7.00.

Competition will be for the Duval County Medical Society Trophy, won last year by Dr. Edson J. Andrews of Tallahassee, and the Orlando Loving Cup, awarded to Dr. Henry H. Bryant III of Coral Gables.

Members of the Woman's Auxiliary will hold their annual tournament with a separate list of prizes, including the Orange County Medical Society Trophy for low gross.

Scientific Exhibits

Many Florida physicians have prepared Scientific Exhibits to show the results of their work. These exhibits are grouped together in a section of the Exhibit Hall. A list is included in the official program.

Convention Committees

Anglers

Robert F. Dickey, Chairman
John T. Kilpatrick
Thomas S. Gowin

Golf

Rene A. Torrado, Chairman
John H. Tanous
Lester A. Russin

Meetings of Specialty Societies

Saturday and Sunday

FLORIDA ALLERGY SOCIETY

G. Frederick Hieber, President ... St. Petersburg
James. H. Putman, Pres.-Elect ... Miami
I. Irving Weintraub, Secy.-Treas. ... Gainesville

Sunday, May 3

Americana — Rooms 202-203

5:00 Business Meeting

7:00 p.m. "Respository Injection Treatment of Inhalant Allergy," Ethan Allan Brown, Boston, Mass.

Visitors welcome.

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

Breckinridge W. Wing, President ... Orlando
George C. Austin, Pres.-Elect. ... Miami
James D. Beeson, Vice Pres. ... Jacksonville
George H. Mix, Secy.-Treas. ... Lakeland

Saturday, May 2

Americana — Rooms 202-203

5:00 p.m. Board of Directors Meeting

Sunday, May 3

Americana — Westward Room

9:00 a.m. Business Meeting and Election of Officers

FLORIDA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

George L. Baum, President ... Coral Gables
M. Eugene Flipse, Vice Pres. ... Miami
Ivan C. Schmidt, Secy.-Treas. ... W. Palm Beach
Charles F. Tate Sr., Program Chairman ... Miami

Sunday, May 3

Americana — Medallion Room

8:40 a.m. Business Meeting

9:00 a.m. "Inhalational Therapy in a Modern Hospital, A New Approach," James Traitz

Allen Armstrong, Discussion leader

9:20 a.m. "Vocal Cord Paralysis Related to Lesions in the Neck and Thorax," Nathaniel M. Levin

James D. Moody, Discussion leader

9:40 a.m. "The Effect of Molar Lactate in Quinidine and Procaine Amide Intoxication," Fred Wasserman

Hyman J. Roberts, Discussion leader

10:00 a.m. "Resection in Pulmonary Tuberculosis," Ivan C. Schmidt

Hawley H. Seiler, Discussion leader

10:20 a.m. "Intestinal Duplication Cyst of the Abdominal Wall Presenting in the Thorax," Harold C. Spear

Francis P. Cassidy, Discussion leader

10:40 a.m. "Effect of Respiratory Obstruction on the Ventilatory Response to Inhaled Carbon Dioxide," Philip Samet

Asher Marks, Discussion leader

11:00 a.m. Emphysema Panel
George L. Baum, Moderator

Jerome Benson; Mark Wolcott, and Asher Marks

12:00 Luncheon and Business Meeting—Bermuda Room

1:00 p.m. "Histoplasmosis," Michael L. Furcolow, Kansas City, Kansas

1:50 p.m. "Auricular Tumors," Martin S. Belle

Francisco Hernandez, Discussion leader

2:10 p.m. X-Ray Seminar (Those in attendance are requested to bring x-rays for discussion after a brief pertinent history)

3:00 p.m. Adjournment

FLORIDA SOCIETY OF DERMATOLOGY

Kenneth J. Weiler, President ... St. Petersburg
Meyer Yanowitz, Vice Pres. ... Miami
Jack H. Bowen, Secy.-Treas. ... Jacksonville

Program and place of meeting to be announced

FLORIDA ACADEMY OF GENERAL PRACTICE

Charles R. Sias, President ... Ocala
Walter J. Glenn Jr., Pres.-Elect. ... Orlando
Elmer B. Campbell Jr., Vice Pres. ... Jacksonville
A. MacKenzie Manson, Secy.-Treas., Jacksonville
Cecil M. Peek,
Program Chairman ... West Palm Beach

Sunday, May 3

Americana — Caribbean Room

9:00 a.m. Board of Directors Meeting

Tuesday, May 5

Americana — Westward Room

8:00 p.m. "Evolution of the Policies of the Commission on Hospitals," Charles C. Cooper, Chairman, Committee on Hospitals, American Academy of General Practice

Business Session

NOTE: Rooms have been assigned to the various specialty groups in the Americana Hotel. The Florida Medical Association is not to furnish projectng lanterns or any of the equipment necessary for the holding of such meetings.

FLORIDA HEALTH OFFICERS' SOCIETY

Henry I. Langston, President.....Apalachicola
Chester L. Nayfield, Vice Pres.....Winter Haven
Lorenzo L. Parks, Secy.-Treas.....Jacksonville

Sunday, May 3

Americana — Rooms 204-205

10:00 a.m. "Restoration of the Stroke Cases," Claire F. Ryder, Div. of Chronic Diseases, U.S. Public Health Service, Washington
Discussion

10:25 a.m. "A Study of Hospital Discharges Among Civilian Population of Monroe County," J. L. Wardlaw Jr., Director, Monroe County Health Department, Key West
Discussion

10:45 a.m. "You Are Here by Accident," J. Basil Hall, Director, Lake County Health Department, Tavares
Discussion

11:00 a.m. "Diabetes Case Finding Among Relatives of Indigent Diabetics in Florida," James Turvaville, Health Field Worker, State Board of Health, Jacksonville
Discussion

11:15 a.m. "Implications for Public Health of the Findings of the Governor's Citizens Medical Committee," Albert V. Hardy, Asst. State Health Officer, Jacksonville
Discussion

11:45 a.m. Business Session

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

Gordon H. McSwain, President.....Arcadia
Lloyd J. Netto, Pres.-Elect.....W. Palm Beach
Fred H. Albee Jr., Vice Pres.....Daytona Beach
John H. Mitchell, Secy.-Treas.....Jacksonville

(Scientific Session and Social Hour to be held in conjunction with Thirteenth Annual Meeting of the Florida Orthopedic Society)

Saturday, May 2

Americana — Medallion Room

2:00 p.m. Scientific Session
"Some Common Orthopedic Problems in Industry," George F. Wilkins, Medical Director, New England Telephone and Telegraph Co.; Clinical Professor of Occupational Medicine at Harvard University; Past President of Industrial Medical Association; Surgeon; Author, and Lecturer.

3:00 p.m. 'Disability Evaluation for Low Back Conditions," Earl D. McBride, Oklahoma City, Okla.

6:00 p.m. Cocktail Party—Carioca Terrace

Sunday, May 3

Americana — Carioca Room

9:00 a.m. Business Session (Separate meeting of each society)

FLORIDA SOCIETY OF INTERNAL MEDICINE

W. Dean Steward, President.....Orlando
Lawrence E. Geeslin, Pres.-Elect.....Jacksonville
John M. Packard, Vice Pres.....Pensacola
Charles K. Donegan, Secy.-Treas.....St. Petersburg

Sunday, May 3

Americana — Barbados Room

9:30 a.m. Minutes of previous meeting
President's address
Secretary-Treasurer's report
Report of Committees:
1. Membership
2. Charter and By-Laws
3. Liaison
4. Legislation
5. Re-write pamphlet "What is an Internist?"
6. Permanent Fee Schedule Committee
7. Annual meeting
8. Communication

Report of Delegates to American Society of Internal Medicine
Report of Nominating Committee
Old Business
New Business

11:00 a.m. Annual Address—(speaker to be announced)

FLORIDA NEUROSURGICAL SOCIETY

James G. Lyerly Sr., President.....Jacksonville
W. Tracy Haverfield, Pres.-Elect.....Miami
Edward J. Sullivan Jr., Secy.-Treas., Jacksonville

Sunday, May 3

Americana — Room 206

10:00 a.m. Presentation of Problem Cases, Christian Keedy, Moderator

10:45 a.m. Presentation of Operative Techniques, W. Tracy Haverfield, Moderator

11:30 a.m. Business Meeting

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

Joseph W. Douglas, President.....Pensacola
Homer L. Pearson Jr., Pres.-Elect.....Miami
T. Bert Fletcher Jr., Secy.-Treas.....Tallahassee

Saturday, May 2

Americana — Floridian Room

6:30 p.m. Cocktail Party—Starlite Patio

Sunday, May 3

Americana — Floridian Room

8:00 a.m. Executive Committee Meeting — Breakfast — Executive Board

9:00 a.m. Business Meeting and Election of Officers

10:00 a.m. "Urinary Incontinence," Erle Henriksen, Associate Professor of Gynecology, U.C.L.A. School of Medicine, Los Angeles.

FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Edson J. Andrews, President ..... Tallahassee
G. Dekle Taylor, Pres.-Elect ..... Jacksonville
Kenneth S. Whitmer, First Vice Pres. ..... Miami
William H. Anderson Jr.,
Second Vice Pres., ... Ocala
Joseph W. Taylor, Secy.-Treas. ..... Tampa

Saturday, May 2

Americana — Bal Masque Room

2:30 p.m. President's Address

Scientific Session

Edward W. D. Norton, Professor of Ophthalmology, University of Miami School of Medicine

"Mucoceles, Their Diagnosis and Treatment," J. R. Chandler, Professor of Otolaryngology, University of Miami School of Medicine

Film—National Foundation for Blindness

6:30 p.m. Cocktail Party—Americana—Westward Room

Sunday, May 3

Americana — Bal Masque Room

9:00 a.m. Scientific Session

"The Cellular Basis of Otolaryngologic Practice," Alvan G. Foraker, Pathologist, Baptist Memorial Hospital, Jacksonville

Movie—"Cataract Section with Preplaced Sutures," Alton V. Hallum, Clinical Professor of Ophthalmology, Emory University School of Medicine, Atlanta, Ga.

General Session
Annual Report, Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director

Presentation of the Past President's Key

Business Meeting and Election of Officers

FLORIDA ORTHOPEDIC SOCIETY

Luther C. Fisher Jr., President ..... Pensacola
Theodore Norley, Vice Pres. ..... W. Palm Beach
Wendell J. Newcomb, Secy.-Treas. ..... Pensacola
Theodore Norley,
Program Chairman ..... W. Palm Beach
Fred H. Albee Jr.,
Program Co-Chairman ..... Daytona Beach

(Scientific Session and Social Hour to be held in conjunction with the Florida Association of Industrial and Railway Surgeons)

Saturday, May 2

Americana — Medallion Room

2:00 p.m. "Some Common Orthopedic Problems in Industry," George F. Wilkins, Medical Director, New England Telephone and Telegraph Co., Boston

3:00 p.m. "Disability Evaluation for Low Back Conditions," Earl D. McBride, Oklahoma City, Okla.

6:00 p.m. Cocktail Party — Carioca Terrace

Sunday, May 3

Americana — Bermuda Room

9:00 a.m. Business Meeting (Separate meeting of each society)

FLORIDA SOCIETY OF PATHOLOGISTS

Ira C. Evans, President ..... St. Petersburg
W. Ansell Derrick, Vice Pres. ..... Orlando
James B. Leonard, Treas. ..... Clearwater
Clarence W. Ketchum, Secy. ..... Tallahassee

Friday, May 1

Saturday, May 2

Jackson Memorial Hospital Clinical Laboratory

9:00 a.m. - 5:00 p.m. Symposium on Instrumentation

Sunday, May 3

Americana — Floridian Foyer

9:00 a.m. Business Session

FLORIDA PEDIATRIC SOCIETY

Burns A. Dobbins Jr., President, Fort Lauderdale
Harry M. Edwards, Pres.-Elect ..... Ocala
Fred I. Dormon Jr., Treas. ..... Lakeland
Camillus S. L'Engle, Secy. ..... Jacksonville

Saturday, May 2

Americana — Pan American Room

2:00 p.m. "Diagnostic Problems in Pediatric Cardiology," H. R. Cooper, Senior Physician, National Children's Cardiac Hospital; Cardiology Staff, University of Miami School of Medicine

3:00 p.m. "Correlation of Clinical and Hemodynamic Cardiovascular Data," Francisco A. Hernandez, Clinical Director, National Children's Cardiac Hospital; Asst. Clinical Professor, Department of Medicine, University of Miami School of Medicine

6:00 p.m. Cocktail Party—Caribbean Room

Sunday, May 3

Americana — Pan American Room

9:00 a.m. "Pediatric Cardiovascular Therapy," H. R. Cooper

10:00 a.m. Panel Discussion: Francisco A. Hernandez, H. R. Cooper, and Robert S. Litwak, Asst. Professor of Surgery, University of Miami School of Medicine

11:30 a.m. Business Meeting

FLORIDA SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

Grover W. Austin, President ..... St. Petersburg
Clifford C. Snyder, Vice Pres. ..... Miami
Bernard L. N. Morgan, Secy.-Treas. ... Jacksonville

Saturday, May 2

Americana — South American Room

9:30 a.m. Breakfast Meeting

FLORIDA PROCTOLOGIC SOCIETY

Sam N. Sulman, President ..... Orlando
Don C. Robertson, Secy.-Treas. ..... Orlando

Saturday, May 2

Americana — Westward Room

10:00 a.m. "Carcinoma of the Anus," Fred A. Vincenti, Mt. Dora

10:25 a.m. "Carcinoma of the Rectum and Colon: A Review of 253 Cases," Willard H. Bernhoft, Asst. Clinical Professor, University of Buffalo, Chief of Proctology at Millard Fillmore and E. J. Meyer Memorial Hospitals, Buffalo, N. Y.

10:50 a.m. "Local Anesthesia for Ano-Rectal Surgery," W. J. Rabhan, Savannah, Ga.

11:15 a.m. "Villous Adenomas of Large Intestine," Myron W. Wheat, Assistant Professor of Surgery, College of Medicine, University of Florida, Gainesville

11:45 a.m. Panel discussion of papers presented

12:30 p.m. Luncheon—Westward Room

2:00 p.m. Business Meeting and Election of Officers

3:00 p.m. Round Table Discussion of Interesting Proctologic Problems (2-3 min. each) Sam N. Sulman, John J. Cheleden, Don C. Robertson, and other members of Proctologic Society

6:30 p.m. Cocktail Party—Miami Shores Country Club

7:30 p.m. Dinner—Miami Shores Country Club

FLORIDA PSYCHIATRIC SOCIETY

James L. Anderson, President ..... Miami
Samuel R. Warson, Pres.-Elect. ..... Sarasota
Samuel G. Hibbs, Secretary ..... Tampa

Saturday, May 2

Americana — Gaucho Room

2:00 p.m. Scientific Session

"A Clinical Study of Trifluoperazine (Stelazine)," Henry L. Dean, Assistant Professor of Psychiatry, University of Miami School of Medicine, and Jack Skigen, Miami

"The Role of Group Therapy in Psychiatry," Lester A. Stepner, Assistant Professor of Psychiatry, and Bernard Tumarkin, Clinical Instructor of Psychiatry, University of Miami School of Medicine, Miami

6:00 p.m. Cocktail Party—Pan American Room

Sunday, May 3

Americana — Gaucho Room

9:00 a.m. Business Meeting

FLORIDA RADIOLOGICAL SOCIETY

C. Robert DeArmas, President ..... Daytona Beach
John P. Ferrell, Vice Pres. ..... St. Petersburg
Russell D. D. Hoover,
Secy.-Treas. ..... West Palm Beach

Program and place of meeting to be announced

FLORIDA ASSOCIATION OF GENERAL SURGEONS

J. Rocher Chappell, President ..... Orlando
Robert E. Zellner, Vice Pres. ..... Orlando
Harry H. Ferran, Secy.-Treas. ..... Orlando

Sunday, May 4

Americana — Westward Room

7:30 p.m. Panel: Threatened Restrictions of General Surgical Privileges, J. Rocher Chappell, Moderator, C. Burling Roesch, and Walter Rautenstrauch Jr.

Business Session; Election of Officers

FLORIDA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Duncan T. McEwan, President ..... Orlando
George W. Morse, Vice Pres. ..... Pensacola
C. Frank Chunn, Secy.-Treas. ..... Tampa
Donald W. Smith, Program Chairman ..... Miami

Sunday, May 3

Americana — Theatre Auditorium

10:00 a.m. Scientific Session

"Clinical Correlation Conference with Case Presentation," John J. Farrell, University of Miami School of Medicine, Miami; Edward R. Woodward, College of Medicine, University of Florida, Gainesville

"Premalignant Lesions of the Breast — Hormonal Influence," Murray M. Copeland, Georgetown University Medical Center, Washington, D. C.

6:00 p.m. Social Hour — Bermuda Room

FLORIDA UROLOGICAL SOCIETY

Melvin M. Simmons, President ..... Sarasota
Edwin W. Brown, Pres.-Elect ... West Palm Beach
Henry L. Smith Jr., Secy.-Treas. ..... Tallahassee

Sunday, May 3

Americana — Eastward Room

10:00 a.m. Program to be announced

5:30 p.m. Cocktail Party—Eastward Room

Other Meetings

BLUE SHIELD OF FLORIDA

Russell B. Carson, President ..... Fort Lauderdale
George S. Palmer, Vice Pres. ..... Tallahassee
Hunter B. Rogers, Vice Pres. ..... Miami
John T. Stage, Secretary ..... Jacksonville
Mr. H. A. Schroder, Asst. Secy. ..... Jacksonville
Floyd K. Hurt, Treasurer ..... Jacksonville
Samuel M. Day, Asst. Treasurer ..... Jacksonville

Saturday, May 2

Americana — Rooms 202-203

2:00 p.m. Board of Directors Meeting

FLORIDA CANCER COUNCIL

Joseph J. Zavertnik, Chairman ..... Miami
Lorenzo L. Parks, Secretary ..... Jacksonville
Millard B. White ..... Sarasota
Robert F. Dickey ..... Miami
Turner E. Cato ..... Miami
Samuel B. D. Rhea ..... Pensacola
Courtlandt D. Berry ..... Orlando

Sunday, May 3

Americana — Room 206

8:30 p.m. Business Meeting

STATE BOARD OF HEALTH

Sunday, May 3

Americana — Room 207

9:00 a.m. Meeting
Chas. J. Collins, President
Wilson T. Sowder, State Health Officer

FLORIDA MEDICAL ASSOCIATION MEDICAL ADVISORY COMMITTEE TO THE STATE DEPARTMENT OF PUBLIC SAFETY

Sunday, May 3

Americana — Room 207

5:00 p.m. Meeting

FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT

Sunday, May 3

Americana — Rooms 204-205

8:00 p.m. Annual Meeting; Election of Officers
Clyde O. Anderson, State Chairman, St. Petersburg
O. E. Harrell, Secy.-Treas., Jacksonville



The pool and an exterior view of the Americana Hotel.

First Meeting House of Delegates

Sunday, 2:30 p.m.

GRAND BALLROOM

Delegates assemble at the Credentials Committee table at the entrance to the Grand Ballroom at 2:30 p.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Thomas C. Kenaston, Chairman
Melvin M. Simmons
Paul F. Baranco

Delegates are to occupy seats in the designated section. Other members of the Association and guests are requested to occupy seats in the other sections of the room.

3:00 p.m., President Annis in the Chair

Invocation: Homer L. Pearson Jr.

Parliamentarian for the President: Joseph S. Stewart

Number of eligible delegates present, report by Thomas C. Kenaston

Motion to seat delegates if quorum is present

Recognition: President, The Florida Bar, O. B. McEwan

Approval of minutes of 1958 Annual Meeting as published in July, 1958, Journal

Gavel to First Vice President, S. Carnes Harvard

President's Address: Jere W. Annis

President resumes Chair

Recognition: Guests

Recognition: Woman's Auxiliary and other guests

Report: Homer L. Pearson Jr., Secretary, State Board of Medical Examiners

Report: Representative to Student A.M.A. Convention

Election of one Delegate to complete term of Louis M. Orr, who resigned. (Term expires Dec. 31, 1959.)

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year term beginning Jan. 1, 1960.

(Terms expiring Dec. 31, 1959: Delegate completing term of Louis M. Orr; Alternate, Richard A. Mills)

Election of a fourth Delegate and Alternate to A.M.A. House of Delegates for a term ending Dec. 31, 1959

Election of a fourth Delegate and Alternate to A.M.A. House of Delegates for two year term beginning Jan. 1, 1960.

(A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President Annis

1. HEALTH AND EDUCATION

Bermuda Room

Eugene B. Maxwell, Chairman
Walter J. Glenn Jr.
Frederick H. Bowen
Laurie J. Arnold Jr.
Gordon H. McSwain

2. PUBLIC POLICY

Barbados Room

Henry J. Babers Jr., Chairman
N. Worth Gable
Achille A. Monaco
Robert F. Dickey
John V. Handwerker Jr.

3. FINANCE AND ADMINISTRATION

Pan American Room

Herbert E. White, Chairman
Ralph S. Sappenfield
James T. Cook Jr.
Robert L. Tolle
H. Quillian Jones

4. LEGISLATION AND MISCELLANEOUS

Eastward Room

Edward W. Cullipher, Chairman
Leo M. Wachtel
Eugene G. Peek Jr.
Ralph M. Overstreet Jr.
George S. Palmer

5. CHARTER AND BY-LAWS

Westward Room

Francis T. Holland, Chairman
Floyd K. Hurt
L. Washington Dowlen
Marion W. Hester
Madison R. Pope

Reports of Committee Chairmen and Resolutions:

(Reference Committee No. 1)

Scientific Work, Lawrence E. Geeslin
Medical Postgraduate Course, Turner Z. Cason
Venereal Disease Control, Lorenzo L. Parks
Tuberculosis and Public Health, Hawley H. Seiler
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
Cancer Control, Robert F. Dickey
Report of Secretary, State Board of Medical Examiners, Homer L. Pearson Jr.
Report of Representative to Student A.M.A. Convention

(Reference Committee No. 2)

Conservation of Vision, Marion W. Hester
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, S. Carnes Harvard
Representatives to Industrial Council, Pascal G Batson Jr.
Grievance, Frederick K. Herpel
Nursing, Thomas C. Kenaston
Blood, James N. Patterson
Resolution: Liaison Committee with State Board of Health

(Reference Committee No. 3)

Address of President, Jere W. Annis
Board of Governors, Jere W. Annis
Necrology, Leo M. Wachtel
Advisory to Woman's Auxiliary, L. Washington Dowlen
Councilor Districts and Council, Warren W. Quillian
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell

Civil Defense and Disaster, W. Dean Steward
Advisory to Blue Shield, Henry J. Babers Jr.
Medicare Mediation, Burns A. Dobbins Jr.
Resolution: Medicare Contract

(Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton
Mental Health, Sullivan G. Bedell
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.
Aging, Samuel Gertman
Delegates to A.M.A.: Louis M. Orr, Reuben B. Chrisman Jr., and Francis T. Holland
Resolutions: Social Security for Physicians
Training Center for Retarded Children
Selection of Physicians Participating in Rehabilitation Program

(Reference Committee No. 5)

Proposed Charter and By-Laws
Other business
Announcements
Adjournment

General Session

Monday, May 4

Grand Ballroom

9:30 a.m. Call to Order

Presiding: Jere W. Annis, President

Invocation: Father Joseph Devaney, Holy Redeemer Church, Miami

Address of Welcome
Robert P. Keiser, Coral Gables, President, Dade County Medical Association

Introduction of Fraternal Delegates: J. W. Chambers, La Grange, Ga., Delegate; Lee Howard Sr., Savannah, Alternate

Announcements

9:55 a.m. President's Guest. To be announced

10:25 a.m. **"A.M.A. Reorganization,"** F. J. L. Blasingame, Chicago, Executive Vice President, American Medical Association

10:45 a.m. Recess to visit exhibits

GENERAL SCIENTIFIC ADDRESSES

Presiding: Lawrence E. Geeslin

11:00 a.m. **"The Dilemma of Modern Therapeutics,"** Ethan Allan Brown, Boston

11:20 a.m. **"Surgical Therapeusis of the Adrenals,"** John J. Farrell, Miami

11:40 a.m. **"Use of Gold in the Treatment of Rheumatoid Arthritis,"** L. Maxwell Lockie Sr., Buffalo

12:00 Adjournment

The Technical Exhibits are an important part of the Eighty-Fifth Annual Convention. They are located in the Exhibit Hall. Be sure to spend some time there as an expression of your appreciation to the firms represented.

OTHER MEETINGS; SOCIAL FUNCTIONS

BOARD OF PAST PRESIDENTS

Americana — Gaucho Room

8:00 a.m. Breakfast

Election of a Chairman and Secretary

Walter C. Jones, Chairman, and William C. Roberts, Secretary

(According to precedence, Eugene G. Peek Sr. will succeed the present chairman and Jere W. Annis the present secretary.)

THETA KAPPA PSI

Americana — Dominion Coffee House

12:00 Luncheon
All attending must register with young lady at marked table in lobby

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REFERENCE COMMITTEES

2:00 to 4:00 p.m.

No. 1. Health and Education—Bermuda Room
No. 2 Public Policy—Barbados Room
No. 3 Finance and Administration—Pan American Room
No. 4. Legislation and Miscellaneous—Eastward Room
No. 5. Charter and By-Laws—Westward Room

BLUE SHIELD

Americana — Grand Ballroom

4:00 p.m. Annual Meeting; Election of Officers

PRESIDENT'S RECEPTION

Americana — Starlite Patio

6:15-7:15 p.m. No formal program. Tickets $3.00 per person, available at Association's registration desk during registration hours or entrance to Patio prior to Reception

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TULANE MEDICAL ALUMNI

Americana — Caribbean Room

6:00 p.m. Cocktail Party followed by dinner. Dean Lapham, speaker. All attending must register with young lady at marked table in lobby

Scientific Assemblies

Tuesday, May 5

GRAND BALLROOM

Morning Session

Presiding: Richard Reeser Jr.

9:30 a.m. **"Polio-Like Diseases in South Florida,"** M. Michael Sigel, Ph.D.; M. J. Takos, M.D.*; G. G. Schlaepfer, B.A.; M. C. Launer and R. V. Cating, R. N., Miami. Presented by Dr. Sigel.

This paper concerns incidence of polio or polio-like disease, many with ECHO 9 virus, that occurred in south Florida. Illness is most frequent in children.

Discussion: Nathan J. Schneider, Ph.D., Jacksonville

9:55 a.m. **"Spontaneous Pneumothorax: Its Complications and Treatment"**
Nelson H. Kraeft, Tallahassee

Care in the diagnosis of spontaneous pneumothorax is stressed. Medical and surgical management of the condition occurring in 32 patients, all men except one, are described in detail.

Discussion: Rodes C. Garby, St. Petersburg
Lawrence C. Manni, Tallahassee

10:20 a.m. **"Clinical Variations in Thyrotoxicosis"**
Miles J. Bielek, Fort Lauderdale

Observations of 100 cases of thyrotoxicosis observed in 1957 and 1958 at North Broward General Hospital, Radio Isotope Clinic, are the basis of this discussion. Slides are shown and certain specific clinical signs are stressed.

Discussion: William A. Abelove, Miami
Samuel W. Root, Jacksonville

10:45 a.m. Recess to visit exhibits

Presiding: John M. Packard

11:00 a.m. Symposium: Cardiovascular Problems

"Problems Encountered in a Vascular Clinic," Clyde M. Collins, John H. Terry and Robert H. Still Jr., Jacksonville. Presented by Dr. Collins.

A concise but inclusive presentation of peripheral vascular diseases is augmented by indications for the various diagnostic and therapeutic possibilities.

Discussion: John R. Emlet, Pensacola

"Arterial Aneurysms: Florida's Problems"
David S. Hubbell, St. Petersburg

The incidence of arteriosclerotic and traumatic aneurysms is increasing in Florida, but so is the availability of surgical correction. Treatment of typical aneurysms is discussed.

Discussion: Harold C. Spear, Miami

"Experimental and Clinical Use of Intravenous Fibrinolysin Therapy"
Paul W. Boyles, Coral Gables

An ingenious method allows x-ray measurement of lysis of radio-opaque thrombi in dog veins and coronary arteries. Results in humans are also discussed.

Discussion: George T. Harrell, Gainesville

Afternoon Session

Presiding: Franz H. Stewart

2:00 p.m. **"Facial Pain"**
C. MacKenzie Brown, Tampa

The importance of a careful medical evaluation is stressed, together with neurologic, allergic, ophthalmologic and otolaryngologic studies. Other diagnostic measures of definite value are discussed.

Discussion: Edward J. Sullivan Jr., Jacksonville
Breckenridge W. Wing, Orlando

2:25 p.m. **"The Office Diagnosis of Masked Depression"**
Robert G. Steele, Sarasota

Early depressions may masquerade behind physical symptoms and Dr. Steele suggests that this may be particularly true in our more senior citizens. He calls attention to the need of early recognition of these reactions.

Discussion: John B. Liebler, Coral Gables
John M. Caldwell Jr., Miami

2:50 p.m. **"Central Angiospastic Retinopathy, an Ocular Vasoneurotic Syndrome"**
Thomas S. Edwards, Jacksonville

Abrupt unilateral disturbances of vision associated with vasospasm should be recognized. Possible precipitating factors, associated consequences, and its relationship to other conditions are discussed. A typical case is presented.

Discussion: Shaler Richardson, Jacksonville
W. Dean Steward, Orlando

3:15 p.m. Recess to visit exhibits

Presiding: George T. Harrell

3:30 p.m. Symposium: "Third Greatest Cause of Death"

"Automotive Crash Injury Research"
Paul W. Braunstein, New York, Surgical Consultant, Automotive Crash Injury Research Project, Department of Public Health and Preventive Medicine, Cornell University Medical College

A study of the types and extent of injuries sustained can be applied to the design of automobiles. The acceptance by the public and manufacturers of safety features should be encouraged.

* Deceased

"Accident Proneness in the Automobile Accident Field"

Frank E. Maloney, LL.B., Gainesville, Acting Dean, College of Law, University of Florida

Legal problems of accident proneness concern restrictions on licensing and operation as well as the liability of the operator for injuries incurred.

"Physical Impairments as They Relate to Accidents"

C. W. Keith, Tallahassee, Captain, Florida State Department of Public Safety

People with physical handicaps can safely operate machines including automobiles. Physicians should cooperate with law enforcement agencies in the safe use of appliances and drugs.

"Accidents, A Family Problem"

Harry C. Steed Jr., Atlanta, Director, Accident Prevention Unit, Georgia State Department of Public Health

Home accidents require the efforts of the whole family for prevention. All accidents have serious economic effects on the family. Family tensions may be a contributing factor.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read.

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any subject."

Committee on Scientific Work: Lawrence E. Geeslin, Jacksonville, Chairman; Richard Reeser Jr., St. Petersburg; George T. Harrell, Gainesville; John M. Packard, Pensacola, and Franz H. Stewart, Miami.

Second Meeting House of Delegates

Wednesday, 9:00 a.m.

Grand Ballroom

Delegates sign official attendance cards at 9:00 a.m. at the table of the Credentials Committee, Thomas C. Kenaston, Chairman, Melvin M. Simmons and Paul F. Baranco, located at entrance to the Grand Ballroom. No alternates are to be seated for Delegates attending Sunday's meeting.

9:30 a.m., President Annis in the Chair

Number of eligible Delegates present, report by Thomas C. Kenaston

Presentation of Life Certificates

Recommendations of Reference Committees:

No. 1 Health and Education
Eugene B. Maxwell, Chairman

No. 2 Public Policy
Henry J. Babers Jr., Chairman

No. 3 Finance and Administration
Herbert E. White, Chairman

No. 4 Legislation and Miscellaneous
Edward W. Cullipher, Chairman

No. 5 Charter and By-Laws
Francis T. Holland, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon

President-Elect
First Vice President
Second Vice President
Third Vice President
Secretary-Treasurer

Dr. Ralph W. Jack escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Jack

Presentation of Past President's Button and Certificate of Honor to Dr. Jere W. Annis by Dr. Ralph W. Jack, President

Benediction, Homer L. Pearson Jr.

Adjournment

TECHNICAL EXHIBITS

The Exhibit Hall will be open until 12:30 p.m., Wednesday, at that time the exhibitors may begin dismantling their booths.



The tropical garden of the Americana Hotel has tended areas in abstract geometric patterns, separated by reefs of native Florida coral.

Technical Exhibits

Technical exhibits are located in the Exhibit Hall of the Americana Hotel. They have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting. The following firms have arranged for exhibits at the Bal Harbour meeting:

Exhibitors	Booth
Abbott Laboratories	28
American Ferment Co., Inc.	232
Anderson Surgical Supply Co.	233
A. S. Aloe Co.	322
Arlington-Funk Laboratories	37
Atlas Pharmaceutical Laboratories, Inc.	31
Audio-Digest Foundation	35
Ayerst Laboratories	122
Borcherdt Co.	312
The Borden Co.	102
Brayten Pharmaceutical Co.	118
George A. Breon and Co.	221
Burroughs Wellcome and Co.	218
Carnation Co.	6
G. W. Carnrick Co.	224
Wilmot Castle Co.	225
Chicago Pharmacal Co.	121
Ciba Pharmaceutical Products, Inc.	110
The Coco-Cola Co.	313
Desitin Chemical Co.	105
Dictaphone Corp.	324
The Doho Chemical Corp.	323
Dome Chemicals, Inc.	11
Drug Specialties, Inc.	320
Eaton Laboratories	219
Encyclopaedia Britannica, Inc.	109
Enfield's	328
C. B. Fleet Co., Inc.	316
Florida Brace Corp.	112
Geigy Pharmaceuticals, Div. of Geigy Chemical Corp.	2
Great Books of the Western World	304
Guild of Prescription Opticians of Florida	30
Charles C. Haskell & Co.	310
Health Insurance Council	119
Hoffman-LaRoche, Inc.	18
Holland-Rantos Co., Inc.	331
Keleket X-Ray of Florida	101
Keisacker	305
Eli Lilly and Co.	308
R. J. Lindquist Co.	231
Loma Linda Food Co.	318
J. A. Majors Co.	201
Maltbie Laboratories	321
S. E. Massengill Co.	29
Mead Johnson and Co.	325
Medco Products	36
Medical Protective Co.	223
Medical Supply Co. — Miami	27
Medical Supply Co. of Jacksonville	216
Merck Sharp & Dohme, Inc.	327
The Wm. S. Merrell Co.	26
C. V. Mosby Co.	220
Nordson Pharmaceutical Labs., Inc.	303
Organon, Inc.	108
Ortho Pharmaceutical Corp.	16
Parco Surgical Supplies	314
Parke, Davis & Co.	330
Pepsi Cola Co.	9
Pet Milk Co. Research Division	111
Pfizer Laboratories	19
Wm. P. Poythress & Co., Inc.	317
The Purdue Frederick Co.	103
Reed and Carnrick	104
R. J. Reynolds Tobacco Co.	332
Riker Laboratories	311
A. H. Robins Co., Inc.	120
Ross Laboratories	302
Sanborn Co.	319
Sandoz Pharmaceuticals	106
SchenLabs Pharmaceutical, Inc.	113
Schering Corp.	17
Julius Schmid Co.	329
G. D. Searle & Co.	315
Sherman Laboratories	4
Smith, Kline & French Laboratories	309
E. R. Squibb & Sons	229
Surgical Equipment Co. — Miami	227
Surgical Equipment Co. of Tampa	228
Surgical Supply Co.	307
Tailby-Nason Co., Inc.	123
Taylor Laboratories	230
The Upjohn Co.	226
VanPelt & Brown, Inc.	326
Walker Laboratories	140
Wampole Laboratories	14
Warner-Chilcott Laboratories	107
Westwood Pharmaceuticals	301
White Laboratories, Inc.	306
Winthrop Laboratories	8

Scientific Exhibits

Americana — Exhibit Hall

Booth No.	
5	Dade County Medical Association, Robert P. Keiser, M.D., President
10	Carcinoma of the Breast, John J. Fomon, M.D.
12-13	Your Glands — American Medical Association, Mr. James R. Hickox, Mgr. Exhibit Section
15	The Treatment of Quinidine and Procaine Amide Intoxication, Fred Wasserman, M.D., Asst. Dir., Professional Services for Research, Veterans Administration Hospital, Coral Gables
20	National Clearing House Program — American Association of Blood Banks, William P. Murphy Jr., M.D.
21	Physiologic Basis of Hypotension and Its Treatment During Anesthesia and Surgery, J. Gerard Converse, M.D., and Edward A. Talmage, M.D.
22-23	Radioisotope Program at Broward General Hospital, Miles J. Bielek, M.D., and Robert J. Poppiti, M.D.
24-25	Renal Artery Hypertension — A Correctible Clinical Condition, Paul T. DeCamp, M.D.; Robert Birchall, M.D., and Hugh Batson, M.D., New Orleans
114	Compound Injuries of the Hand, Principles of Treatment, Duncan M. McKee, M.D.
115	Maternal and Child Health
116	Florida Division, American Cancer Society, Mr. L. H. Peterson
117	Progressive Muscular Dystrophy, Miss Anita E. Posselt, Muscular Dystrophy Association of America, Inc., New York
124	Woman's Auxiliary to the Florida Medical Association, Mrs. Lee Rogers, President

125 Florida Medical Foundation
126 Twenty Years Experience With a Continuous Traction Hip Screw, Herbert W. Virgin Jr., M.D.
127 Myasthenia Gravis, Mrs. Glendora E. Arthur, The Myasthenia Gravis Foundation, Inc., New York
128 A New Rapid Staining Technique for Office Practice, Nuri Sagiroglu, M.D. The Cancer Institute at Miami
129 Penicillin Reactions — Their Diagnosis and Treatment, William T. Strauss, M.D., New York
130 Virus and Cancer; Virus and Injury to Blood Vessel Wall, Ben McConnell, M.D., Southern Bio-Research Institute, Florida Southern College, Lakeland
131 Radiation Protection, Raymond E. Parks, M.D.
132 Bowel Normalization, Gordon McHardy, M.D., New Orleans
133 Common Ocular Problems, Dan M. Gordon, M.D., New York
134-135 Industrial Safety — Equipment and Problems, Thomas E. Daly, M.D., and Mr. Phil Lawson, Pratt-Whitney Aircraft, W. Palm Beach
136 Risk-Oriented Psychotropic Screen for Institutions, Charles H. Carter, M.D.
137 Sunland Training Center at Gainesville, Charles H. Carter, M.D.
138 Obstructing Vascular Rings, DeWitt C. Daughtry, M.D.; John G. Chesney, M.D., and Harold C. Spear, M.D.
139 Insurance Program — Florida Medical Association, Mr. Leyton B. Hunter, Marsh & McLennan, Inc., Atlanta
202 University of Miami School of Medicine, Homer F. Marsh, Ph.D., Dean
204 Disaster Planning, Lorenzo L. Parks, M.D.
205 Acceptable Operations for Duodenal Ulcer, Emmet Ferguson Jr., M.D., and Harry Reinstine, M.D.
206 A New Aid to Tonsil Surgery, Robert E. Ryan, M.D., St. Louis, Mo.
207 Recent Advances in the Physiologic Evaluation of Patients with Heart Disease, Philip Samet, M.D.; William H. Bernstein, M.D., and Robert S. Litwak, M.D.
208 Surgical Treatment of Abnormal Involuntary Movements, David Fairman, M.D.; Irwin Perlmutter, M.D., and Richard E. Strain, M.D.
209 A Review of Juvenile Amputees, Newton C. McCollough, M.D.
210 The Dangers in the Application of Traction for Fractures of the Femur in Children, Joseph C. Flynn, M.D.
211 Plastic and Reconstructive Surgery; Its Contribution to Community Medicine, Thomas J. Zaydon, M.D.
212-213 Strike Back at Stroke: Early Mobilization of the Stroke Patient, Claire F. Ryder, M.D., Division of Chronic Diseases, Dept. of Health, Education and Welfare, Washington
214 Blue Shield of Florida, Inc., Russell B. Carson, M.D.
215 Bureau of Professional Relations, Mr. Charles S. Haupt, College of Pharmacy, University of Florida
222 Cogeners: Chemistry-Pharmacology, Mr. Alexander W. Biddle, Institute of Public Information, New York

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PROGRAM
THIRTY-SECOND ANNUAL MEETING
WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION

HOSTESS AUXILIARY: Woman's Auxiliary to the Dade County Medical Association

Convention Chairman ....Mrs. William P. Smith
Co-Chairman .....Mrs. Donald F. Marion

CONVENTION COMMITTEE CHAIRMEN

Arrangements Committee ..... Mrs. Reuben B. Chrisman Jr.
Decoration Committee....Mrs. Frank W. Hewlett
Auxiliary Room Exhibits Committee ....Mrs. Robert P. Keiser
Medical Association Exhibits Committee.....Mrs. Richard D. Owen
Hospitality Committee....Mrs. Robert F. Dickey
Publicity Committee .....Mrs. John W. Dix
Luncheon Committee .....Mrs. Henry H. Bryan
Mrs. Francis N. Cooke
Golf Tournament Committee ..... Mrs. Manuel A. Schofman
Registration Committee....Mrs. Frederick B. Zaugg

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions Committee ..... Mrs. Alfred P. Seminario
Election Committee .....Mrs. Joseph W. Farrington
Reading Committee .....Mrs. Bernard M. Barrett
Timekeepers Committee Mrs. Lawrence G. Hebel
Observers Corps .....Mrs. Breckenridge W. Wing

GENERAL INFORMATION

GENERAL REGISTRATION will be held along with registration of members of the Florida Medical Association at the Americana Hotel, Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m.

REGISTRATION FOR DELEGATES to Auxiliary House of Delegates, 8:30 a.m. to 9:30 a.m., Monday, May 4 (Location to be announced).

AUXILIARY MEETINGS: All meetings and activities are to be held at the Americana Hotel, Bal Harbour.

HOSPITALITY ROOM for all physician's wives will be open Sunday, Monday, and Tuesday. Ask at the hotel Information Desk regarding its location.

TRANSPORTATION to Lincoln Road will be available, a courtesy of the hotel.

DAILY SCHEDULE

Sunday, May 3

Caribbean Room

1:00 p.m. Pre-Convention Board of Directors Meeting .....Mrs. Lee Rogers Jr., Presiding



Mrs. Lee Rogers Jr.
President, Woman's Auxiliary



Mrs. Wendell J. Newcomb
President-Elect, Woman's Auxiliary

2:30 p.m. Florida Medical Association House of Delegates — Recognition of Auxiliary
Dr. Jere W. Annis, Presiding

3:30 p.m. Board will reconvene if necessary.

4:00 p.m. State Membership Committee Meeting Mrs. Wendell J. Newcomb, Presiding (Meeting will be held in suite of Auxiliary President and President-Elect)

Monday, May 4

Caribbean Room

9:30 a.m. ANNUAL MEETING OF THE HOUSE OF DELEGATES, WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION. ALL AUXILIARY MEMBERS ARE INVITED TO ATTEND

1:00 p.m. ANNUAL LUNCHEON: Medallion Room
Blessing ..... Mrs. Marvin L. Kokomoor
Address: Dr. F. J. L. Blasingame, Executive Vice-President of the American Medical Association
Entertainment ..... Dade County Auxiliary

4:00 p.m. to

5:30 p. m. Interview Hour in suite of Auxiliary President and President-Elect

6:30 p.m. Florida Medical Association President's Reception ..... Starlite Patio

Tuesday, May 5

Pan American Room

9:00 a.m. Post-Convention Board of Directors Meeting ..... Mrs. Wendell J. Newcomb, Presiding

10:30 a.m. School of Instruction

PROGRAM FOR ANNUAL MEETING HOUSE OF DELEGATES
Monday, May 4, 9:30 a.m.

CALL TO ORDER: Mrs. Lee Rogers Jr., President

INVOCATION: Mrs. H. Quillian Jones

PLEDGE OF LOYALTY: To the Woman's Auxiliary to the Florida Medical Association. I pledge my loyalty and devotion to the Woman's Auxiliary to the Florida Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

Led by Mrs. Clarence R. Crandall

ADDRESS OF WELCOME: Mrs. Maurice M. Greenfield, President, Woman's Auxiliary to the Dade County Medical Association

RESPONSE TO THE WELCOME ADDRESS: Mrs. J. Denny Moffett Jr.

INTRODUCTIONS: Mrs. Lee Rogers Jr.

REMARKS FROM CHAIRMAN OF ADVISORY BOARD: Dr. L. Washington Dowlen

PRESENTATION OF CONVENTION CHAIRMEN AND ANNOUNCEMENTS: Mrs. William P. Smith, Convention Chairman

REMARKS ABOUT WOMAN'S AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION:
Mrs. George Owen, President
Woman's Auxiliary to the Southern Medical Association

MEMORIAL SERVICE: Mrs. Albert F. Stratton Jr.

BUSINESS SESSION:

CONVENTION RULES OF ORDER: Mrs. Thomas C. Kenaston, Parliamentarian
ROLL CALL OF VOTING DELEGATES: Mrs. John P. Ferrell, Recording Secy.
MINUTES OF THE THIRTY-FIRST ANNUAL MEETING: Mrs. Ferrell
REPORT OF REGISTRATION: Mrs. Frederick B. Zaugg

REPORTS OF STATE OFFICERS AND COMMITTEE CHAIRMEN:
NOTE: If there is no objection, the reports of state officers and chairmen will be accepted as printed and placed on file, except

for such reports that require action by the body of the convention and those which must be presented orally, as required by our By-Laws. Those reports that must be given orally, according to the By-Laws, are those of the Treasurer, the Finance Chairman, the Florida Auxiliary Medical Education Fund Chairman, and the Revisions and Resolutions Chairman.

REPORTS OF PRESIDENTS OF COMPONENT AUXILIARIES:

Alachua: Mrs. Marvin L. Kokomoor
Bay: Mrs. Joseph H. Morris
Brevard: Mrs. Clarence R. Crandall
Broward: Mrs. Floyd A. Osterman
Dade: Mrs. Maurice M. Greenfield
Duval: Mrs. Joseph W. Farrington
Escambia: Mrs. Bernard M. Barrett
Hillsborough: Mrs. Joseph C. Flynn
Jackson-Calhoun: Mrs. Grayson C. Snyder
Lake Sumter: Mrs. Frederick C. Andrews
Lee: Mrs. H. Quillian Jones
Leon, et al: Mrs. George H. Massey
Manatee: Mrs. John L. Jennings
Marion: Mrs. Harry F. Watt
Orange: Mrs. Breckenridge W. Wing
Palm Beach: Mrs. James R. Anderson
Pinellas: Mrs. Alfred P. Seminario
Polk: Mrs. Clyde E. Asbury Jr.
Putnam: Mrs. Laurence G. Hebel
St. Johns: Mrs. George C. Hopkins Jr.
St. Lucie: Mrs. Maltby F. Watkins
Sarasota: Mrs. Thomas R. Young Jr.
Seminole: Mrs. Gordon D. Stanley
Volusia: Mrs. Gerald S. Williams

UNFINISHED BUSINESS

NEW BUSINESS

REPORT OF THE COURTESY RESOLUTIONS COMMITTEE: Mrs. Seminario

ELECTION OF 1960 NOMINATING COMMITTEE

ELECTION OF DELEGATES TO THE NATIONAL CONVENTION

REPORT OF THE 1959 NOMINATING COMMITTEE: Mrs. Perry D. Melvin, Chairman

ELECTION OF 1959-1960 AUXILIARY OFFICERS

MESSAGE FROM THE FLORIDA MEDICAL ASSOCIATION: Dr. Jere W. Annis, President

INSTALLATION OF OFFICERS: Mrs. Richard F. Stover, First Vice-President, Woman's Auxiliary to American Medical Association

PRESENTATION OF GAVEL AND PRESIDENT'S PIN: To the new president by Mrs. Rogers

PRESENTATION OF PAST PRESIDENT'S PIN: To Mrs. Rogers by Mrs. Perry D. Melvin

INAUGURAL MESSAGE: Mrs. Wendell J. Newcomb

ADJOURNMENT

Technical Exhibit

A feature that adds materially to the success of the annual convention is the technical exhibits. Each firm represented features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and on Wednesday from 8:30 a.m. to 12:30 p.m. The booths may be dismantled after 12:30 p.m.

GEIGY PHARMACEUTICALS 2
Yonkers, N. Y.

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its technical display. Information on products valuable in the therapy of rheumatic, metabolic, dermatologic and cardiovascular diseases will be presented by personnel in attendance.

SHERMAN LABORATORIES 4
Detroit, Mich.

Protamide: A sterile colloidal solution. Published clinical studies have convincingly established Protamides value in neuritis, herpes zoster and other nerve root pains.

Elixophyllin: Severe asthmatic attacks are not merely relieved, but terminated in 10 to 20 minutes by Elixophyllin, given orally. In milder attacks, its speed has been described as "instantaneous."

Vital capacity increases were noted as soon as five minutes after administration.

CARNATION COMPANY 6
Los Angeles, Calif.

Carnation Company cordially invites you to visit booth 6 where medical specialist representatives will be pleased to welcome old and new friends of the Florida Medical Association. A refreshing sample drink of Carnation Instant Nonfat Milk with fresh milk flavor and instant solubility will be served you.

ORTHO PHARMACEUTICAL CO. 16
Raritan, N. J.

Ortho cordially invites you to visit booth 16 where the well known line of obstetrical and gynecological pharmaceuticals will be on display. Featured will be Ortho preparations for conception control. Ortho representatives will welcome the opportunity to discuss their products with you.

SCHERING CORP. 17
Bloomfield, N. J.

Schering welcomes the physicians of Florida. We cordially invite you to visit the Schering booth where representatives will be on hand to discuss with you the most recent advances in tranquilizer, antihistaminic and corticosteroid therapy. Products such as Schering's Trilafon, Polaramine and Deronil will be featured.

THE WM. S. MERRELL CO. 26
Cincinnoti, Ohio
Quiactin for quieting . . . an improvement over present tranquilizers for tension, anxiety states; patients remain alert, feel better. Simron, a new low dose iron, provides full therapeutic response in treatment of iron deficiency anemia.

You are invited to discuss these and other Merrell research products with our representatives.

ABBOTT LABORATORIES 28
North Chicogo, Ill.
Exhibit will feature the Abbott Laboratories Antibiotic Triad—three products which together provide control of all coccal infections: Erythrocin ® Stearate, Compocillin-VK ® and Spontin ®. Also shown will be Abbott's unique new "metered release dose form" products, Tral Gradumets ® and Desoxyn Gradumets ®, plus a selection of other Abbott specialties.

AUDIO-DIGEST FOUNDATION 35
Glendale, Calif.
Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast," compiled and reviewed by a professional Board of Editors, may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally recognized authorities.

THE BORDEN CO. 102
New York, N. Y.
Most important new item at the Borden Pharmaceutical Division's booth is Liquid Bremil which adds all the convenience of a liquid to the significant advantages already established by Bremil Powdered. Borden's full line of formula products is on display including Mull-Soy, the original hypoallergenic formula. Other new additions are Dermabase and Junitar, the nonstaining tar bath, and Marcelle Hypoallergenic Cosmetics, pure beauty aids for delicate skins.

THE PURDUE FREDERICK CO. 103
New York, N. Y.
The Purdue Frederick Co. will present: Cerumenex: Cerumenolytic for the quick removal of excessive cerumen. Contains Cerapon, a new surfactant, with propylene glycol and chlorbutanol. Senokot: Neuroperistaltic constipation corrective containing the total senna glycosides. Senokap: Stool softener, combining the action of dioctyl sodium sulfosuccinate with that of Senokot. Senokot with Psyllium: Combines the bulk effect of psyllium with Senokot. Senobile: Combines the bile salt effect with Senokot. ProBilagol: Cholecystokinetic containing d-glucitol and homatropine methylbromide. for biliary disease therapy.

REED & CARNRICK 104
Jersey City, N. J.
Members of the Florida Medical Association and their guests are invited to visit the Reed & Carnrick exhibit located in Booth No. 104. On display will be: Sycotrol, the new antiphobic indicated when fear-anxiety results in functional complaints of the cardium or G.I. tract; Modutrol, psycho-physiological approach to peptic ulcer therapy, that is antiphobic, antispasmodic, antacid; and Alphosyl the tar allantoin lotion for psoriasis. Our representatives will be pleased to provide information on these and other Reed & Carnrick specialties.

DESITIN CHEMICAL CO. 105
Providence, R. I.
Desitin Ointment: Pioneer CLO ointment for treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder: Saturated with CLO, dainty, relieves chafing, sunburn, diaper rash, etc.; Desitin Hemorrhoidal Suppositories and Rectal Ointment: Relieve pain and itching, promote healing, give comfort in uncomplicated hemorrhoids, fissures. No anesthetics or styptics. Desitin Baby Lotion: Protective, antiseptic, emollient, contains no mineral oil, cleanses baby skin with tender care. Desitin Acne Cream: A non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris, skin blemishes, effective in removal of skin oiliness, antiseptic. Desitin Cosmetic and Nursery Soap: Supermild, pleasantly scented, antiseptic and deodorant.

SANDOZ PHARMACEUTICALS 106
Hanover, N. J.
Sandoz Pharmaceuticals cordially invites you to visit our display featuring Mellaril, the first potent tranquilizer with a selective action (i.e.—no action on vomiting centers.) This unique action gives specific relaxation with safety at all dosage levels. Bellergal Space Tabs assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate. Cafergot PB, the most effective oral mdication for the relief of migraine headache with G.I. disturbance accompanied by tension.

WARNER-CHILCOTT LABORATORIES 107
Morris Plains, N. J.
The Warner-Chilcott booth will feature the following: Choledyl has been highly effective in the treatment of bronchial asthma, bronchospasm and congestive heart failure. Choledyl assures high oral theophylline blood levels, with minimal side reactions; it rarely produces fastness. Proloid—the total thyroid complex—doubly assayed, biologically as well as chemically. Proloid's purity and rigid standardization assure the physician of a smooth predictable clinical response whenever thyroid therapy is indicated. Tedral—to control the symptoms of bronchial asthma—provides three specific actions against major symptoms. Prescribed on a continuous daily dosage schedule, Tedral and Tedral Enteric Coated provide an ideal prophylactic therapy to keep the patient symptom-free day and night.

ORGANON, INC. 108
Orange, N. J.
Physicians are cordially invited to visit the Organon booth for information on new therapeutic specialties. Among these will be: Stenisone, Organon's brand of doubly-protected prednisone; Cortrophin-Zinc, a new and improved aqueous ACTH; Wigraine, the complete and rapid-acting migraine therapy; Medache, a new and safe analgesic calmative; and Nugestoral, for the treatment of abortion-prone patient. Organon representatives will be glad to discuss these advances in therapy with all interested physicians.

PET MILK CO. 111
St. Louis, Mo.
We will be pleased to have you stop and discuss the variety of time saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and Instant "Pet" Nonfat Dry Milk for special diets.

SCHENLABS PHARMACEUTICALS, INC. 113
New York, N. Y.
SchenLabs cordially invites you to discuss with our representatives the important discovery Neutrapen—the only specific for penicillin reactions which eliminates successfully about 97 per cent of allergic reactions to penicillin. Also featured will be other unique products of SchenLabs research and development progress.

HEALTH INSURANCE COUNCIL 119
New York, N. Y.
The Health Insurance Council's exhibit is designed to provide general information on health insurance as underwritten by insurance companies. In addition, it also makes available, information on Uniform Claim Forms for use by doctors and hospitals in support of health insurance claims.

CHICAGO PHARMACAL CO. 121
Chicago, Ill.
Products which will be featured include: Prenaphos: The most complete prenatal therapy tablet, backed by a unique protection program. Be sure to get information on how you can make available to your pregnant patients protection against fetal mortality or involuntary abortion. Details will gladly be given by our representative at the booth. Urised: Nationally known and clinically proven tablet for both comfortable sedation and thorough antisepsis in all types of genitourinary affections. Juniplex: An excellent tasting liquid tonic for both children and adults which contains all the essential minerals as well as the entire B complex plus 30 micrograms of B12 per teaspoonful.

AYERST LABORATORIES 122
New York, N. Y.
Physicians are invited to visit booth 122 where Ayerst representatives will be on hand to welcome them and discuss any Ayerst specialties of interest to them.

TAILBY-NASON CO., INC. 123
New York, N. Y.
Betadine Antiseptic—a new iodine complex devoid of iodine burn. Non-irritating film forming germicide fungicide for use as topical antiseptic and therapeutic bactericide. Betadine exhibits all of iodine's potent microbicidal activity and is especially effective against antibiotic resistant Staph. Aureus. Betadine is available in solution and Aerosol Spray and Vaginal Douche.
Also on display will be Supertah "white coal tar" Ointments in three forms: plain, with sulfur and salicylic acid, and with hydrocortisone. These cosmetically elegant, stainless ointments are indicated for such resistant dermatological conditions as psoriasis, dermatophytosis, pruritus and infantile eczema.

WALKER LABORATORIES, INC. 140
Mount Vernon, N. Y.
Peptolin, a tonic for relief of chronic fatigue will be featured. Peptolin is a palatable, deep brown elixir, with a sparkling sherry wine base—providing a mood elevator and energizer with vitamins, iron, minerals and bioflavonoids. Geralin, a comprehensive "one capsule daily" dietary supplement as an aid toward better nutrition, continuing health and vigor. Supplied in a most appealing and pharmaceutically elegant apothecary jar. Hedulin, the oral anticoagulant of choice. Full details pertaining to the drug and reprints of all medical papers are available in complete portfolio form.

J. A. MAJORS CO. 201
Dallas, Texas
The latest editions published by W. B. Saunders Co. will be on display: DePalma "Atlas of Fractures and Dislocations;" Wohl "Long Term Illness;" Cecil "Textbook of Medicine" (new 10th edition); Duncan "Metabolism" (new 4th edition) and many others.

BURROUGHS WELLCOME & CO. 218
Tuckohoe, N. Y.
The extensive research facilities of "B. W. & Co." both here and in other countries, are directed to the development of improved therapeutic agents and techniques. An informed staff will be at our booth to discuss our products and latest developments.

EATON LABORATORIES 219
Norwich, N. Y.
Furoxone ® (brand of furazolidone) liquid and tablets solve acute diarrheal disease problems, swiftly relieve symptoms, rapidly destroy bacterial pathogens (bactericidal rather than bacteriostatic), succeed where others fail against the enteric "problem pathogens"—increasingly prevalent, refractory strains of Staphyococcus, Escherichia, Salmonella and Shigella without creating new problems.

THE C. V. MOSBY CO. 220
St. Louis, Mo.
Among the recent medical and surgical books are featured Anderson's "Pathology" and Miale's "Laboratory Medicine—Hematology." You are invited to examine the new 1959 releases: "Physical Diagnosis" by Prior and Silberstein; "Bone Tumors" by Lichtenstein; "Textbook of Surgery," 3rd edition, by Moseley; "Surgical Pathology" by Ackerman; "Therapeutic Radiology" by Moss; "Patient Care and Surgery of the Foot" by Du Vries; "Anesthesia for Infants and Children" by Smith; "New Orleans Academy of Ophthalmology Symposium on Glaucoma" by Clark; "Synopsis of Treatment of Anorectal Diseases" by Ross; "The Care of Minor Hand Injuries" by Flatt and "A Synopsis of Diagnosis and Treatment of Ear, Nose and Throat Diseases" by Ryan, Thornell and Von Leden.

THE MEDICAL PROTECTIVE CO. 223
Fort Wayne, Ind.
The Medical Protective Co., originator of professional protection exclusively, now in its sixtieth year, provides unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered, plus unparalleled experience from the successful handling of some 78,000 claims and suits in the professional liability field.

G. W. CARNRICK CO. 224
Newark, N. J.
G. W. Carnrick Co. representatives will be waiting to greet you at the exhibit. Among the products featured will be Bontril, the well known anti-obesity product, Penite, for prevention of anginal attacks and Nolamine, a new oral nasal decongestant in the form of a timed-release tablet. Nolamine is designed to exert decongestion and antihistaminic activity over a period of 8 to 10 hours with a single dose.

WILMOT CASTLE CO. 225
Rochester, N. Y.
Demonstration of proper sterilizing techniques using both single and double shell portable autoclaves will highlight the Castle presentation this year. Representatives will outline proper methods of wrapping, sterilizing and storing instruments, dressings, gloves, packs, syringes, and liquids. The demonstration will include discussion of proper autoclave operation, with details on filling, steam buildup, air evacuation, timing, venting, and drying of supplies.
Also featured will be the Company's new number 8 Surgical Spotlight, and inexpensive multi-beam illuminator available in floor, wall and ceiling models.

THE UPJOHN CO. 226
Kalomazoo, Mich.
Professional representatives of The Upjohn Co. are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

E. R. SQUIBB & SONS 229
New York, N. Y.
E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical profession in new products or improvements in products already marketed. At booth 229, we are pleased to present up-to-date information on these advances for your consideration.

AMERICAN FERMENT CO., INC. 232
New York, N. Y.
Have you tried TOD'L, the sudsing, emollient, antibacterial skin cleanser for the treatment and prevention of various skin affections? Also featured: Caroid and Bile Salts as a logical complement in modern methods of therapy; Falgos buffered analgesic; Alcaroid Antacid, and Supligol for non-surgical biliary problems.

WESTWOOD PHARMACEUTICALS 301
New York, N. Y.
Westwood invites physicians to stop by their booth to discuss their unique dermatological products: Fostex Cream, Fostex Cake, Sebulex, Lowila Cake and Lowila Emollient. These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

ROSS LABORATORIES 302
Columbus, Ohio
As adjunct to the physician's oral reassurance of anxious new parents the Ross Developmental Series offers visual materials (individual case records, behavioral development folders, emotional development booklets). Current concepts stress development of the infant as a whole being. Physiologic infant feeding may be discussed with your Similac representative.

NORDSON PHARMACEUTICAL LABS., INC. 303
Irvington, N. J.
Levonor, a new compound for suppression of appetite without CNS overstimulation, will be featured. The smooth action of Levonor permits its use during evening hours; it may be given as late as 8:00 p.m. without keeping the patient awake. Late clinical studies will be available. Also displayed: Ferronord liquid and Ferronord tablets—the chelate hematinic that provides more rapid hemoglobin response with virtually no undesirable side effects.

MILLER SURGICAL CO. 305
Chicago, Ill.
See the Miller Electro-Surgical Units and Accessories such as snares, suction-coagulation attachments, grasping forceps, etc. Also complete line of diagnostic equipment consisting of illuminated otoscope, ophthalmoscope, eyespud with magnet, transillumination lamps, mirror headlite, vaginal speculum with smoke ejector and Gorsch operating scopes and stainless steel proctoscopes, all sizes, with magnification.

SURGICAL SUPPLY CO. 307
Jacksonville, Fla.
The Surgical Supply Company invites all to stop by their booth to see the latest instruments and devices of interest to doctors.

ELI LILLY AND CO. 308
Indianapolis, Ind.
You are cordially invited to visit the Lilly exhibit located in space No. 308. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

SMITH, KLINE & FRENCH 309
Philadelphio, Pa.
S.K.F. features: Temaril ® tablets and syrup—oral medications for the relief of itching, both chronic and acute; Vi-Sorbin®, a potent modern tonic containing B 12, B6, iron, folic acid and the absorption enhancement factor, D-Sorbitol; Compazine®, the tranquilizer and antiemetic remarkable for its freedom from drowsiness and depressing effect; and Thorazine®, one of the fundamental drugs in medicine.

CHARLES C. HASKELL & CO. 310
Richmond, Va.
The Haskell representative will be happy to discuss new developments in connection with the familiar Belbarb, Hasamal, Hasacode products. In addition will be featured Dipral, a new product for the treatment of rheumatic disease.

RIKER LABORATORIES, INC. 311
Los Angeles, Colif.
Riker Laboratories, Inc. presents Deaner® a totally new agent for the treatment of chronic fatigue states, mild depression, chronic headache, migraine, neurasthenia, behavior problems and learning defects in children. Riker representatives at Booth 311 will be glad to supply you with complete information on this new product, Deaner.

BORCHERDT CO. 312
Chicago, Ill.
Two time-tested products are being shown at this meeting. Malt Soup Extract for constipation and intractable pruritus ani. This dietary product acts on the intestinal flora to produce a predominantly aciduric flors. Urolitia is a mild soothing urinary antiseptic for geriatric patients. Register for samples and information on these products.

G. D. SEARLE & CO. 315
Chicago, Ill.
You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle products of research.
Featured will be Dartal, the new tranquilizing agent which controls activities associated with anxiety states and other neuroses; Enovid, the new synthetic steroid for treatment of various menstrual disorders; Zanchol, a new biliary abstergent; Nilevar, the new anabolic agent, and Rolicton, a new safe, nonmercurial oral diuretic. Also featured, will be Vallestril, the new synthetic estrogen with low incidence of side reactions; ProBanthine and ProBanthine with Dartal, the standards in anti-cholinergic therapy; and Dramamine and Dramamine-D, for prevention and treatment of motion sickness and other nausea.

C. B. FLEET CO., INC. 316
Lynchburg, Va.
Fleet will feature Clysmathane, its most recent contribution in the field of medication by rectum—an advanced method of xanthine therapy. Clysmathane is a stable solution of theophylline monoethanolamine; easily retained, rapid and uniform absorption, prompt and predictable blood levels; with no rectal irritation after prolonged use. Clysmathane, in a disposable rectal unit, makes self-administration easy any time, any place—and assures prompt therapeutic blood levels. Examine the unit and ask that samples and literature be mailed to your office.

WM. P. POYTHRESS & CO., INC. 317
Richmond, Va.
A cordial welcome awaits you from Bob Bush at the Poythress booth. Solfoserpine, new distinctive combination of reserpine, phenobarbital, and colloidal sulfur; Mudrane, outstanding anti-asthmatic tablet; Solfoton, and other well established Poythress products will be featured. We will be grateful for your requests for literature and trial supplies.

LOMA LINDA FOOD CO. 318
Arlington, Calif.
With the background of years of experience in perfecting a hypoallergenic milk powder, and also a newly developed concentrated liquid milk the protein of which is fully derived from the soybean and formulated with other essential additives to care for the needs of babies, growing children, and adults, the Loma Linda Food Company will be happy to welcome you to their exhibit. Attendants will be pleased to discuss the values of Soyalac powder and concentrated liquid. Samples of this flavorful product will be served at the exhibit.

SANBORN CO. 319
Waltham, Mass.
New Electrocardiographs of advanced design and function, as well as latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 319.
Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.
Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

MALTBIE LABORATORIES
DIV. WALLACE & TIERNAN, INC. 321
Belleville, N. J.
Maltbie Laboratories features the new dermatologic ointment, Caldecort, containing calcium undecylenate, hydrocortisone and neomycin for a comprehensive therapy of skin conditions caused by fungi, bacteria or allergy. Also exhibited are: Desenex, most widely prescribed for athlete's foot; Nesacaine, a safe, potent and rapid-acting local anesthetic; Bifran for the management of the overweight patient; and Cholans for the treatment of hepatobiliary dysfunction.

A. S. ALOE CO. 322
Tampa-Miami
A cordial welcome is extended to the members of the Florida Medical Association to visit the A. S. Aloe Company exhibit. A unique array of surgical, physiotherapy, and laboratory equipment will be displayed.

DOHO CHEMICAL CORP. 323
New York, N. Y.
Doho Chemical Corp. is pleased to exhibit: Auralgan, otitis media and removal of cerumen; Otosmosan, fungicidal and bactericidal in the suppurative and aural dermatomycotic ears; Rhinalgan, nasal decongestant free from systemic or circulatory effect; Larylgan, throat spray and gargle for infectious and non-infectious sore throat involvements.
Mallon Chemical Corp.: Rectalgan, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing; Dermoplast, an aerosol spray for surface pain, burns and abrasions; obs. and gyn. use.

MEAD JOHNSON & CO. 325
Evansville, Ind.
The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

VANPELT AND BROWN, INC. 326
Richmond, Va.
VanPelt and Brown extend a cordial invitation to visit their exhibit where representative will be happy to answer questions and supply clinical samples of their products.

MERCK SHARP & DOHME 327
Philadelphia, Pa.
A new and very promising adrenocortical steroid is featured. Decadron possesses all basic actions and effects of other glucocorticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other known glucocorticoid. Electrolyte imbalance is not ordinarily a therapeutic problem. Neither abnormal salt and water retention nor potassion excretion are discernible in most patients receiving therapeutic dosages. Decadron is generally well tolerated.
Diuril—a diuretic compound that possesses favorable biologic properties common to both the mercurial preparations and the carbonic anhydrase inhibitors is also of interest. Diuril acts essentially without toxic effects or other disadvantages. Following a single oral dose, Diuril produces effects within two hours which lasts for 6 to 12 hours. It is repeatedly effective when administered continuously once or twice daily for a long period.
Technically trained personnel will be present to discuss these and other subjects of clinical interest.

ENFIELD'S 328
Miami-Miami Beach-Jacksonville
Anyone in your office can make itemized patient statements at the touch of a button. Key to this instant electric billing is the Thermo-Fax copying machine. With it, you can prepare 1,000 itemized statements in a single morning. Other important papers, too—even electrocardiograms—in just four seconds. All this office efficiency can be yours for less than the cost of many typewriters. You can share in the time and money savings made possible by this important research development.

JULIUS SCHMID, INC. 329
New York, N. Y.
An interesting and informative exhibit featuring Immolin Cream-Jel for use without diaphragm; Ramses Flexible Cushioned Diaphragm; Ramses Vaginal Jelly; Vagisec Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, Ramses and Sheik Rubber Condoms for the control of trichomonal re-infection.

PARKE, DAVIS & CO. 330
Detroit, Mich.
Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

HOLLAND-RANTOS CO., INC. 331
New York, N. Y.
You are invited to discuss with our representatives: Mechanical advantages of contouring Koro-flex-diaphragms. New, improved Nylmerate jelly and solution for vaginal leucorrheas. Special Koromex(A) for use where "jelly alone" is indicated. Beneficial cutaneous effects of Hollandex ointment (with silicones and natural vitamins A and D) upon contact and neurodermatitis, decubitus ulcers, diaper rash, skin dryness chafing, etc.

R. J. REYNOLDS TOBACCO CO. 332
Winston-Salem, N. C.
Welcome to the R. J. Reynolds Tobacco Company exhibit. You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camel, Winston filter, Methol fresh Salem, or Cavalier king size cigarettes.

PRESIDENT'S PAGE

Ars et Scientia

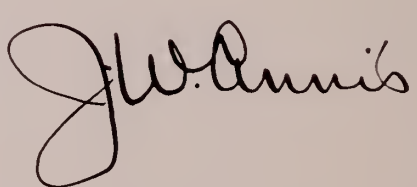
Next month is the Eighty-Fifth Annual Meeting of the Florida Medical Association.

Originally an almost exclusively scientific conclave, this gathering has of late come to represent primarily a social and fraternal affair, at which the socioeconomic aspects of Medicine steal the spotlight. Both of these latter areas of interest are important and vital considerations in the general health of our organization. Let us not, however, forget that the foremost and fundamental purpose of any gathering of physicians is to discuss the professional aspects of Medicine—to exchange ideas regarding the science and the art of our profession—to teach and to learn from the experience of others—to stimulate intellectual pursuits and achievement—to gain mastery of new and effective methods in the unending search for truth—which is the study of Medicine.

This year your Committee on Scientific Work has arranged a program with excellent papers that provide considerable depth in medical talent and medical ideas.

The scientific stature of the meeting has grown to the point where only one application in three could be accepted for a place on this program. Both locally and nationally, the participants have well deserved recognition and reputation, and we are privileged to hear them.

Let us avail ourselves of every advantage and pleasure of this meeting—but let us place attendance at the Scientific Sessions at the top of the list. Let us place first things first.



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Outstanding Program Planned For Eighty-Fifth Annual Meeting

When the Eighty-Fifth Annual Meeting of the Florida Medical Association convenes next month, it will be meeting for the fifteenth time in the greater Miami area. The dates this year are May 2-6, and the place, Bal Harbour, Miami Beach. The headquarters is the resort hotel, the Americana, where last year's meeting was held. Not only does the hotel offer a unique setting for vacationing—you may wish to bring your family—but it is ideally arranged with meeting rooms, an exhibit hall, and the other necessary facilities for a convention the size of the Association's Annual Meeting.

Plans call for continuing the same type of approach as last year. The first session of the House of Delegates will take place on Sunday afternoon in the Grand Ballroom of the hotel from 3:00 to 5:00. There has been a slight change in the time available to the specialty groups, due to the omission of the annual dinner, usually held on Tuesday evening. Please note in the scheduled program that there are specialty meetings on Saturday all day, on Sunday morning and evening, and also on Tuesday evening. The specialty groups will meet principally in the Americana, but a few will hold their meetings in adjacent hotels. Unfortunately, there are some conflicts, but in the few days encompassing this convention, they cannot be avoided.

The general session will be called to order by the President, Dr. Jere W. Annis, on Monday, May 4, at 9:30 a.m. The President's special guest speaker will be presented at 9:55 a.m. Dr. F. J. L. Blasingame, of Chicago, Executive Vice President of the American Medical Association, will then address the convention. He will have some pertinent remarks regarding the problems facing organized medicine, individual practice and group practice.

Following the morning recess to visit the exhibits, a series of three extraordinary addresses will begin at 11:00 a.m. The first speaker will be Dr. Ethan Allan Brown of Boston, a native of London, England, and an internationally known allergist, who will alert the members to some of the problems associated with and arising from



Dr. Blasingame



Dr. Brown



Dr. Farrell



Dr. Lockie

the rapid development of new drugs and to the various types of reactions that can develop in humans from their use. The title of his address is "The Dilemma of Modern Therapeutics."

The next speaker will be Dr. John J. Farrell, Professor and Chairman of the Department of Surgery at the University of Miami School of Medicine, who will elaborate on the surgical treatment of the diseases of the adrenal gland, using as his title "Surgical Therapeusis of the Adrenals."

Because of Florida's prominence as a state with an increasing aging population, it was believed important by the Committee on Scientific Work not to neglect the field of arthritis. Consequently, Dr. C. Maxwell Lockie Sr. of the University of Buffalo School of Medicine was invited to present the latest ideas on the use of gold in the treatment of rheumatoid arthritis. More and more older people are moving to Florida, and Dr. Lockie's address, "Use of Gold in the Treatment of Rheumatoid Arthritis," should be of great interest.

The entire afternoon on Monday will be devoted to the business of the Association as the House of Delegates meets for its first session. All those who are not delegates will have ample opportunity to enjoy the recreational facilities at this time.

The whole day on Tuesday will be occupied by two scientific sessions. The Committee on Scientific Work had great difficulty in making the decision about these presentations because of the great number of excellent papers submitted this year; however, an attempt was made to group those chosen in phases of interest.

For the first half of the program on Tuesday morning, there will be "Polio-Like Diseases in South Florida," by M. Michael Sigel, Ph.D.; "Spontaneous Pneumothorax: Its Complications and Treatment," by Dr. Nelson H. Kraeft, and "Clinical Variations in Thyrotoxicosis," by Dr. Miles J. Bielek. The second half is a symposium on "Cardiovascular Problems"—"Problems Encountered in a Vascular Clinic," by Dr. Clyde M. Collins; "Arterial Aneurysms: Florida's Problems," by Dr. David S. Hubbell, and "Experimental and Clinical Use of Intravenous Fibrinolysin Therapy," by Dr. Paul W. Boyles.

On Tuesday afternoon, the first half of the program will consist of discussions on "Facial Pain," by Dr. C. MacKenzie Brown; "The Office Diagnosis of Masked Depression," by Dr. Robert G. Steele, and "Central Angiospastic Retinopathy,

an Ocular Vasoneurotic Syndrome," by Dr. Thomas S. Edwards.

It was thought advisable, because of the increasing problems in this category, that the "Third Greatest Cause of Death" be discussed more in detail. There has been criticism at times that members of the medical profession do not pay enough attention to the prevention of accidents. Consequently, the last portion of the program will be taken up with a symposium which will approach this subject from the standpoint of four angles—medicine, law, law enforcement and engineering. If time permits, the moderator will elaborate on questionable points by a question and answer period. Speakers for the symposium and the titles of their addresses are: Dr. Paul W. Braunstein, of New York, Surgical Consultant, Automotive Crash Injury Research Project, Department of Public Health and Preventive Medicine, Cornell University Medical College, "Automotive Crash Injury Research;" Frank E. Maloney, LL.B., of Gainesville, Acting Dean, College of Law, University of Florida, "Accident Proneness in the Automobile Accident Field;" C. W. Keith of Tallahassee, Captain, Florida State Department of Public Safety, "Physical Impairments as They Relate to Accidents;" and Harry C. Steed Jr. of Atlanta, Director, Accident Prevention Unit, Georgia State Department of Public Health, "Accidents, A Family Problem."

Lawrence E. Geeslin, M.D., Chairman
Committee on Scientific Work

Economic Aspects of Opening an Office

It has often been said, no doubt with some justification, that doctors are poor business men. After spending 10 to 15 years learning the technical aspect of his profession, a neophyte medic suddenly finds himself face to face with the realities of making a living from the practice of medicine. While it is true that we live not by bread alone, it is equally true that we cannot live without it. The Florida Medical Association is probably unique in that it is composed largely of young physicians, the median age of its members being just over 40 years. For this reason it has been suggested that a consideration of some phases of the economic aspect of running an office might be of value.

Location

Once a physician has decided where he wants to live and practice medicine, he is confronted with the problem of where he will locate his office within the community. Oftentimes this choice will be determined by availability of space, but any location should be measured against the attributes of an ideal setup. These will vary somewhat with the nature of the physician's practice and the size of the community in which he plans to practice; but in general an ideal office site should have the following characteristics:

1. Location on an easily identifiable spot with easy access to public transportation and with ample parking space. While it is true that some people are willing to travel almost to the Canadian border to the Mayo Clinic to see a doctor, the average patient is not going to be troubled riding all over town trying to find an obscure dead-end street to see a doctor of less than national repute. The office should be easily identifiable either itself or by its proximity to some other landmark, such as a lake, a river bend, a tall building, or a park. In spite of the prevalence of automobiles, many people still depend on public conveyances to get about; this dependence makes it highly desirable to be near or on a street on which some conveyances travel. Availability of adequate parking facilities is almost a necessity. People are peculiar animals. Patients will ride around for a half hour looking for a nickel parking space, arrive late for an appointment, and then pay a half dollar fine for overparking rather than park in a 25 cent parking lot adjacent to the doctor's office. The doctor who does not recognize such peculiarities in his patients and who does not provide parking facilities is going to lose a certain part of his practice to the doctor whose office is more accessible.

2. Location in or near the center of populated areas. A young doctor recently opened his office in a large subdivision containing about 5,000 people several miles from the center of town. His idea was that since there was no doctor in the area, he would have a built-in, ready-made practice waiting for him. There was another side of

the picture which he should have considered. Many of those people had already found a family doctor and would not be likely to change. Since the office location was some distance from town, few if any people in town would be liable to make the long trip to his office when many other doctors were more conveniently located. The subdivision in which he was opening his office was composed largely of young people who were in the process of buying a house, a car, a television set, and any number of household appliances and who were more likely to pay doctor bills last than would older, more settled people. Neighborhood practice may be fine, but it has certain disadvantages, especially in an area which does not have a fairly representative cross section of the community.

3. Close proximity to other doctors and laboratory and x-ray facilities. Doctors' offices are somewhat like dime stores in that they tend to thrive most where there are several together. It is desirable that the other physicians be engaged in dissimiliar practices. The neophyte pediatrician, for example, is more likely to get referred patients from the other doctors in his area or building if he is the only pediatrician there than he would if there were two or three established physicians practicing pediatrics close by. Unless the doctor provides his own laboratory and x-ray facilities, these should be conveniently accessible to him elsewhere. Not only does it make his practice easier, but it saves him and his patients time and convenience not to have to send them any great distance for required laboratory procedures.

4. Ground floor versus office building. In general, a ground floor office is preferable to an office building suite with an elevator. Accessibility to elderly, injured or stretcher patients is assured with a ground level entrance, whereas this may not always be true with an office dependent on elevator service.

In summary, an ideal doctor's office site would be a ground level office at an easily identifiable spot close to public transportation, with adequate parking space and in close proximity to other doctors' offices and medical laboratories. To most people one unknown doctor is as good as the next, and before a doctor can begin to build a practice, he must have the opportunity of seeing and satisfying patients. The easier it is for the patients and potential patients to get to him, the more successful his practice is likely to be. The location of his office deserves careful consideration by any physician beginning his practice.

Leasing and Outfitting

Having selected an advantageous office site, next follows leasing the space and outfitting the office. Doctors are generally considered by landlords to be highly desirable tenants. Consequently, many landlords are willing to make concessions to prospective doctor-tenants which they would not make to someone engaged in another business or profession. When a young doctor is first opening his office and has the prospect of several months of greater outgo than income, there are several ways in which he may cushion the full shock of the grand opening. Some landlords will accept a note for the first two or three months' rent, payable at a later date. Others will accept reduced rent for the first six months with the difference added to the rent of the second six months. There are numerous ways whereby such an arrangement can be worked out, and the main thing is for the doctor to know about them and to explore the possibility which best fits his circumstances.

Medical supply houses are usually pleased to equip an office for a doctor and permit him to pay for it on the installment plan at so much a month. Of course, such arrangements carry the usual interest and carrying charges, and it is customary for the doctor to have his life insured for the amount of the loan. Again, the details are unimportant, but it is important for a young man beginning his practice to know that one of the resources he acquired with his M.D. degree was a good credit rating, a most valuable asset when it is necessary to use it.

In selecting an office it is a common mistake among young doctors to get one which is either too small or which will be rapidly outgrown. His first consideration is likely to be how little rent he will have to pay, and he is more than likely to underestimate the rapidity with which his practice will grow. It has been said by economists who should know that it is a poor policy for a doctor to move his office at frequent intervals. Some patients are always lost in the shuffle, and the impression of instability is created by the repeated moves.

On the other hand, it is a waste of money to have more space than one needs. Rents, salaries, telephone, and the like are fixed expenses which go on day or night, rain or shine, whether a practice is good or bad, and it is in this area that the value of each item should be appraised with the eye of a cost accountant. Not only the neophyte but the old-timer should regularly con-

sider his fixed outgo to ascertain if he is actually getting his money's worth. Unless he is in the income bracket where Uncle Sam gets all of it anyway, in which case little said here will be of interest to him, he can probably save himself money from numerous little leaks which he either does not know about or which he has forgotten.

Getting Acquainted

Having outfitted an office and hired an office assistant, what to do until the patients arrive? Announcements should be sent to all other doctors in the community telling of the opening of the new office. When the doctor is practicing in a field in which he may expect referred patients from out-of-town physicians, it is sometimes advisable to send notices to doctors in nearby towns. In some areas it is permissible to insert a small paid announcement in the newspaper. This varies with different localities, and it is generally wise to consult with the county medical society secretary concerning local custom before taking any such action.

One asset a doctor beginning his practice has which his more established colleagues are not likely to have is an abundance of uncommitted time. This may be a most valuable asset if he makes himself generally available. Whenever he is out of his office, his secretary should know where he can be reached by telephone promptly. The great influx into Florida has resulted in large numbers of people with no established relationship with a doctor. Not knowing any doctor, such people are likely to select the one most available. There are other people, too, who may have been to an established doctor who are unwilling either to wait three weeks for an appointment or to sit all day in his office waiting to see him and who will settle for a new doctor. It is not unusual to hear someone say, "Dr. Blank is mighty fine, but he's so busy." The significant word in that statement is *but*. That man is a potentially dissatisfied patient and is fair game for the doctor who will give him the time he thinks he needs. It is an old saw that the hypochondriacs flock to the new doctor, and the physician with the patience to listen will frequently find he has made some friends who will sing his praises far and wide—and possibly send him a patient or two.

While not treating emergencies and listening to hypochondriacs, he will find time well spent visiting other doctors In some places this practice may be considered rather old hat, but it still has much merit. There is no doctor so busy that he is not a bit flattered by the new man's coming by to see him and possibly asking his advice on some subject. The new doctor then becomes more than an announcement card; he becomes a personality. A few days later, the "old" man may have a patient who needs attention sooner than he can see him and he may well send him over to that pleasant young fellow who was nice enough to come by. Such visits should be short, however, or the "old" man may remember not "that nice young fellow," but "that bore who made me an hour late."

On such visits the new doctor can learn a great deal about local practice. However much of an individualist he may be, it is an excellent idea to conform to local practice until he has time to learn his way around. This suggestion applies especially to fees. The doctor who thinks he sets his own fees is really kidding himself. Wittingly or unwittingly, they are set by the medical community and by what is acceptable to the nonmedical community. There may be no published fee schedule, but in every locality there is a house call charge which is fairly standard. If the new doctor charges more, he will soon be branded a gouger not only by the patients but by his colleagues. If he charges less, he is not only losing money, but his patients are likely to think that his services are actually worth less than those of other doctors. A few older, established physicians, may be able to command higher fees, but this ability is one of the privileges of established reputation.

The Patient-Centered Office

Office in operation, the acquaintance of colleagues made, and patients begin to arrive. What can be done to assure that they not only return but that they tell their friends about the new doctor? This is an age in which millions of dollars are spent annually on packaging products in an attractive manner, one which will make them more desirable than the same items not so well wrapped. Doctors, like strawberries, are oftentimes judged by their appearance and by the appearance of their surroundings. Recently, a friend called to inquire about a doctor to whom he had been. His comment was: "I can't imagine his being any good. His office was so dirty."

The patient-centered office is likely to be the successful office. This means giving consideration to several factors, beginning with the secretary. Patients should be greeted by name in a manner

indicating that they are welcome rather than one suggesting that they are imposing on a busy woman's time. It is up to the doctor to train his secretary to operate his office as he wants it done. One occasionally hears, "I think Dr. Blank is a fine fellow, but that secretary of his is a witch." If she is and Dr. Blank permits her to be, he has nobody to blame but himself when his practice suffers. Part of operating a patient-centered office is maintaining a clean, pleasant, comfortable reception room containing a few *current* magazines and periodicals.

The time is rapidly coming to an end when patients will tolerate the come-early-and-take-your-chances-no-appointment operation of doctors' offices. A workman who is losing two to three dollars an hour, an attorney who should be working on a brief, a housewife who needs to be picking up her children at school—all of these people may sit around all afternoon waiting to see a doctor if they are sick enough, but they will not be happy about it, and sometimes this unhappiness manifests itself in their waiting a good long time to pay the doctor's bill. The doctor who refuses to make appointments implies that while his own time is important, that of his patients is worthless. The making—and keeping—of appointments is appreciated by patients as showing real consideration and with a young, not too busy doctor is a practice builder which costs him little.

The disparity which existed 50 years ago between a doctor's education and that of his patients has almost vanished. More people are better educated and are better informed about themselves and about medicine. The physician who discards the attitude of "I know best; do it because I say so," and sits down with his patient to explain in understandable terms what his diagnosis is, what it means, and what he wants his patient to do about it is going to have more satisfied patients—and satisfied patients pay their doctor bills.

Much has been said and written about billing. The trend in recent years has been toward itemizing statements so that people will know for what they are paying. Anything other than routine office charges should be discussed in advance with the patient or the person responsible for paying the bill. Bills outstanding for three months and over can be more effectively collected by a telephone call by the secretary than by a stereotype letter. In setting up a bookkeeping system it is advisable to obtain the services of an accountant. It is possible to buy prepackaged mail order service, but personal accounting services bear the same relationship to the mail order variety as a personal physician's services do to patent medicine.

Insurance

Now, a word about insurance. In this litigious age no doctor should see his first patient without first obtaining professional liability insurance. Just how much coverage he needs will vary with the physician and the community in which he practices. It is a good idea to discuss this matter with the doctors in the area and get their advice on the subject. Other insurance which a doctor should have in his office includes fire and theft, and personal liability. Unless he has adequate savings, he should also have disability income protection. Professional liability (malpractice) insurance policies should never be thrown away. An insurance company is liable for the doctor's protection for a stated 12 month period even though a claim may not be made until five years later. The only evidence that a doctor has that he is protected is his insurance policy.

While this entire discussion has been devoted to the materialistic side of the practice of medicine, it is a truism that the physician who is genuinely interested in people and who is genuinely interested in his profession will do all right in this world and will make a good living. Being a good doctor, however, and being a good business man are not incompatible. The doctor who is a wastrel in the operation of his office is not only short-sighted; he is foolish.

ROBERT E. ZELLNER, M.D.

Hotel Reservations For Association's Meeting

Hotel reservations for physicians attending the Eighty-Fifth Annual Meeting of the Florida Medical Association, May 2-6 should be made directly with the hotel. The Americana Hotel is headquarters for the meeting. Physicians desiring to stay in this hotel should send their reservations to Mr. Edward Pratt, Reservations Manager, Americana Hotel, Bal Harbour, Fla. Date of arrival and departure should be stated.

Dr. Annis Speaks on Role Of Voluntary Health Agencies

Choosing for his subject "The Role of the Voluntary Health Agencies in Modern Medicine and in Public Health," Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, addressed the Tuberculosis and Health Association of Polk County, Inc., on Feb. 5, 1959, at its meeting in Bartow. After reviewing the four main types of voluntary health agencies, Dr. Annis commented:

"Within the past fifty years, the larger and better known national voluntary health agencies have become an accepted part of our culture. These organizations which operate independently of each other and of relative needs, give to all of us that cherished American opportunity for freedom—opportunity for promoting, advertising and promulgating our own particular cause—our own particular charity—the opportunity to obtain for this cause in which we so deeply believe, whatever it may be—more money—more machinery—more technical and professional improvement than any other group may have—an opportunity for success in this, our achievement, limited only by our own ability and our efforts to convince our neighbors of the importance of our cause. This emphasizes the selective giving of charity, and perhaps not the least of its benefits is to the volunteers themselves—by giving them an opportunity to live their philosophy a little bit—to take action on their ideals and principles and experience the sense of accomplishment of a worth while effort.

"I do not believe that this is simply an expression of the American desire for getting into the act. It is, in a way, a fulfillment of a much deeper and basic need in a people who revere free enterprise and unlimited opportunity, as well as the rights of the human being, and who have a basic and fundamental concept that we are, at least to a degree, our brother's keeper. Here, certainly, is an opportunity for the expression of that free enterprise—limited only by the enthusiasm of the workers, and offering the satisfactory accomplishment of reaching that altruistic and worth while goal."

Dr. Annis then pointed out the role of physicians as counselor to these voluntary organizations and the importance of cooperation with organized medicine, beginning with the local county medical society. Looking at the problem from the state level, he noted that prior to the termination of World War II, there were only five voluntary health agencies active in Florida. All others began their work in the state following World War II, and since 1949 organizations of voluntary health agencies with a full time staff have been established at an average rate of more than one a year.

Governor Collins appointed last year a Citizens Medical Committee on Health. Occupying a prominent place in its recently published report is a chapter on the role of voluntary health agencies operating within the state. In its meticulous study, the committee solicited data from each of the voluntary health agencies serving Florida, and received replies from all but one. Some 19 of these subsidiaries of national agencies were contacted. Commenting on the report, Dr. Annis said:

"The report of the Governor's Committee concludes with warm acknowledgement of the activities of the voluntary health agencies within the State, and lauds their effectiveness, as well as the generosity of the citizens of Florida in contributing millions of dollars annually toward these worth while goals. It feels, however, that the situation might be further strengthened—and taking the premise that all funds provided voluntarily for the support of these agencies are to be regarded as public monies, it feels that their disbursement is, to some degree perhaps, a joint responsibility of the agencies accepting these funds. It therefore recommends that such agencies be encouraged to evolve an appropriate State coordinating organization whose activities shall include the interchange of information and experience; the encouragement of effective evaluation of the services performed by an agency; the development, where possible, of interrelated programs; and the establishment of closer liaison with the medical and other related professional groups. It is also felt that an effort might be made to coordinate better the programs of these organizations with official Public Health and other appropriate public agencies. It suggests that the State Board of Health be charged with the responsibility of issuing permits to all voluntary health organizations as a prerequisite to the solicitation of funds in more than one county within the State—so that the public may know that the stamp of approval has been placed upon the honest efforts and administration of these agencies."

The position of the American Medical Association on this problem is basically the same as that outlined, Dr. Annis explained. In conclusion,

he observed, "Certainly all of you are to be commended for your time, your effort, and your industry—and for all the good work that you have done. But—remember—much of the good which you do will be for yourselves."

A. M. A. Speaker Addresses Joint Meeting of Attorneys And Physicians at Tallahassee

The Tallahassee Bar Association and the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society met in joint session in Tallahassee on Feb. 11, 1959. At this meeting, arranged to foster improved relations between attorneys and physicians of the area, the featured speaker was C. Joseph Stetler, Director of the Law Division of the American Medical Association.

Mr. Stetler reminded his audience that the American Medical Association was concerned with the "battle of the medical experts" in personal injury cases as early as 1914, when a special committee of the House of Delegates suggested that medical opinion testimony be limited to experts called by the courts. At that time, however, the House elected to solve the problem through cooperation with the American Bar Association. In his opinion, the fundamental reason why the problem remains unsolved after nearly half a century is the almost universal aversion of doctors to appear in court and testify in a lawsuit. He cited basic reasons for this attitude:

"First, there is a fundamental difference in the method of approach of law and medicine as far as the discovery of truth is concerned. The lawyer attempts to maintain his position by argument and contention with opposing counsel. His life is one of advocacy of causes; his object is to magnify his own arguments and to belittle those of his opponent.

"The physician, on the other hand, works in the free and open atmosphere of the laboratory, hospital, sickroom or private office. He demands a full and frank discussion and disclosure of all phases of a case and finally after all the pertinent facts have been collected, he correlates them and forms a judgment with reference to the illness. By training and practice, therefore, the whole tempo and attitude of the day-to-day experience of the physician and lawyer are totally different."

Emphasizing the need for finding workable solutions to medical testimony problems, Mr. Stetler stated that from 65 to 80 per cent of all litigation in the courts today requires some type of medical reports or testimony and seven out of 10 personal injury cases are decided on medical rather than legal considerations. He warned against the "professional witnesses" in these words: "We consider this new 'medical specialty' as an injustice to the profession and the public and intend to do our best to eliminate it. In this endeavor we are seeking the active assistance of the legal profession, for we know as you do that whenever a doctor is testifying improperly there is always at least one lawyer encouraging and coaching him."

In making a plea for establishment of a better rapport and understanding between the two professions as a solution to the problem, he expressed the belief that the working relationship between physicians and attorneys has definitely improved during the last 12 to 18 months, and not by accident. He cited some of the more significant current medical-legal developments indicating the extent and seriousness of the interest in this field among individual attorneys and physicians and their local, state and national associations. Among them were the ready response of lawyers to an opinion survey of the legal profession currently being conducted by the Law Department of the American Medical Association covering medical professional liability, medical testimony and medical-legal cooperation, interest in the regional medicolegal conferences in strategic cities throughout the country sponsored by the American Medical Association, a series of six medical-legal films currently in preparation and sponsored by the two professions, and the active AMA-ABA Liaison Committee at work nationally.

One most important factor stressed was the promulgation of interprofessional codes, which have now been adopted or are being actively studied in more than 50 cities and states. They contain provisions relating to written reports to be furnished by the doctor, conferences between physicians and attorneys prior to trial, arrangements made in advance for the physician to testify; the conduct of a physician while on the witness stand, and the compensation a physician should obtain for testifying. The new national code adopted by the two national associations last year is similar to many of these codes and contains an important new provision, a section relating to the handling of a complaint or criticism by a member of one profession against the other.

"The American Medical Association, the American Bar Association, and many of the state and local medical and legal societies," Mr. Stetler remarked in conclusion, "are just now becoming sufficiently acquainted with the mutual problems of medicine and the law to initiate concrete efforts at better understanding. The success of these efforts requires the assistance of all ethical and honest physicians and attorneys in the best interest of the public as well as the profession."

Postgraduate Seminar on Surgery Miami, April 30-May 1

The Department of Surgery of the University of Miami School of Medicine will conduct a Post Graduate Seminar at the Jackson Memorial Hospital, Miami, on April 30 and May 1, 1959. Lectures will be held from 9:00 a.m. to 3:30 p.m. and will be followed by ward rounds and laboratory demonstrations.

The Seminar will be opened by Jay F. W. Pearson, Ph.D., President of the University of Miami. The scientific program will consist of the following speakers and their subject: Robert S. Litwak, M.D., "Selection of Patients for Mitral Commissurotomy with Discussion of Results;" David H. Reynolds, M.D., "Management of Acute Head Injuries;" J. Ryan Chandler, M.D., "Current Status of Tonsil and Adenoid Surgery;" Wallace Miller, M.D., "The Treatment of Colles' Fractures;" Frank T. Kurzweg, M.D., "Indications for Surgery in Peptic Ulcer;" John J. Farrell, M.D., "Fluid and Electrolyte Balance: Its Clinical Application;" John J. Fomon, M.D., "Clinical Evaluation of Patients with Arterial Insufficiency;" Edward W. D. Norton, M.D., "Treatment of Eye Emergencies;" Daniel S. Martin, M.D., "The Use of Adjuvant Chemotherapy for the Treatment of Cancer;" George R. Prout, M.D., "Selection of Treatment for Patients with Carcinoma of the Prostate;" A. Sarmiento, M.D., "Evaluation of Patients with Low Back Pains;" and O. J. Menzel, Ph.D., "Detection of Deafness in Children."

The registration fee for the Seminar is $25, payable to the Department of Surgery, Post Graduate Seminar, Jackson Memorial Hospital, Miami.

The Seminar has been approved by the Florida Academy of General Practice for 12 hours' credit in category I. It is being supported in part by Chas. Pfizer & Co., Inc.

Midwinter Seminar of Ophthalmology And Otolaryngology Popular Attraction

The Thirteenth Annual Florida Midwinter Seminar of Ophthalmology and Otolaryngology, held at the Americana Hotel in Bal Harbour, Miami Beach, on February 16 through 21, 1959, attracted an unusually large number of registrants from throughout the nation. Again this year, attendance records attested the ever increasing popularity of this annual gathering at the height of the winter season. The 424 registrants represented 40 states. Florida supplied 58, and New York with 46 had the second largest attendance. Other Eastern states well represented were Pennsylvania with 33, New Jersey and Virginia with 15 each, and Massachusetts with 11. The District of Columbia had seven registrants. An excellent representation from the Midwest included 35 from Ohio, 34 from Michigan, 19 from Illinois, 14 from Indiana, and 10 from Wisconsin. West Coast registrants numbered eight from California, and two each from Oregon and Washington. There were seven from Canada.

This year, the first three days were devoted to Otolaryngology and the last three to Ophthalmology. The distinguished faculty included Dr. John J. Conley of New York City, Dr. George T. Harrell of Gainesville, Dr. William C. Huffman of Iowa City, Iowa, Dr. P. E. Ireland of Toronto, Canada, and Dr. Arthur L. Juers of Louisville, Ky., lecturing on Otolaryngology, and Dr. Frank D. Carroll of New York City, Dr. Paul A. Chandler of Boston, Dr. John W. Henderson of Ann Arbor, Mich., Dr. Edward W. D. Norton of Miami, and Dr. Harvey E. Thorpe of Pittsburgh, lecturing on Ophthalmology.

OTHERS ARE SAYING

Some Simple Rules for the Maintenance of Health and Happiness

Much unhappiness and ill health are of our own making. Observance of a few simple rules will keep most of us out of much serious trouble. It is probably easier to change our ways of life than those of mankind.

Observe the Ten Commandments and apply the Golden Rule.

Shake off regrets for the past, the fears for tomorrow, and start to live happily for today.

Devote a day and night to perfecting plans for better living for yourself.

Define your objectives in life and live so as to attain them.
Cultivate courtesy at home and abroad, especially at home.
Cultivate tastes that are attainable, available and satisfying.
When in doubt, seek guidance from the wise, and ask the Lord in prayer.
Learn to live for others—to give rather than to seek.
Have and express opinions, but avoid useless and provoking arguments.
Cultivate companionship with your betters.
Try to make life one of interest, activities and zest.

If these rules fail—consult your physician or clergyman.

Taken from "Amid Masters of Twentieth Century Medicine," by Leonard G. Rowntree, M.D.

BLUE SHIELD

Commercial Insurance Company Types of Coverage

JOHN A. WILHELM, M.D.
MEDICAL DIRECTOR,
GULF LIFE INSURANCE COMPANY
JACKSONVILLE

We can divide the types of coverage that the so-called commercial carriers issue into two major groups: number one, the group insurance; and number two, the individual sickness and accident contract. The group phase is divided into four major categories; hospital expense protection, surgical expense protection, regular medical expense protection, and major medical expense protection.

Hospital Expense Protection

Hospital expense protection covers everything for which the hospital normally makes a charge. There are two phases in this contract, the daily room and board rate and special charges such as anesthesia, radiology, medications, et cetera.

Surgical Expense Protection

Surgical expense protection is set up on a surgical fee schedule such as Blue Shield has and varies from $150 to $600, depending on which the customer wants to buy. The average is $200 and $300.

Medical Expense Protection

Medical expense protection encompasses the physician's fee other than surgical and usually pays from $3 to $7 per hour or office call.

Major Medical Expense Protection

Major medical expense protection is divided into two phases. The first is major medical which is quite comprehensive and usually has a deductible amount of $200 to $500 with coverage varying from $2,500 to $10,000. Most major medical plans are superimposed upon a basic hospital and surgical coverage. The average deductible feature is set at a level whereby expenses will be taken care of up to say $300 or $400 by the basic plan. There may be a corridor of, for example, $100 before major medical takes over. Major medical plans are based either on the maximum amount for one illness or on the basis of a definite amount for lifetime. Comprehensive medical is the latest type of major medical coverage and is divided into three categories. Type A is the hospital expense which usually has no deductible or co-insurance, but has a maximum of $300, $400, or $500. Seventy-five to 80 per cent of anything over this maximum is paid by the insurance company, the co-insurance, and the balance is paid by the patient. Type B medical expense comprehensive is purely surgical coverage which has no deductible, but is under the co-insurance feature, normally on either the 75 or 80 per cent basis. In other words, the surgical fee can go up to the limit because there is no specified surgical schedule. Type C medical expense is a sort of catchall that includes all other physicians, nurses, et cetera. We believe that this is the answer for a blanket coverage because it has a very small deductible after which the co-insurance feature ensues.

Individual Accident and Sickness Policies

The other major division of health insurance is what we call the individual accident and sickness policy, and this, too, is divided into categories, the cancellable and the noncancellable. Some states have passed legislation limiting the right of the company to cancel a contract. New York has passed legislation which literally con-

verted every cancellable policy into a noncancellable policy. The noncancellable policy is broken into two types, the so-called guaranteed renewable contract with a guaranteed rate versus the guaranteed renewable contract with a right to change the rate by class.

There are several kinds of coverage which are usually not bought in groups, but are more available to the individual, that is, the loss of income from sickness and/or accidents. Loss of income from sickness protection pays so much a month, say for two or four years, with the average contract being for either one or two years. About 75 per cent of the loss of income from accident contracts are issued for a lifetime strictly on an indemnity basis in that if the policy holder is disabled, he receives so much a month. Here the definition of total disability and permanent disability in sickness and accident contracts comes into range. If an individual is unable to perform his usual occupation for the first two years, or in some contracts five years, his disability is recognized. After the two or five year period, he must be disabled as far as any gainful employment is concerned. Naturally, accident and sickness contracts include an accidental death benefit that can be purchased up to $50,000, and, in addition, many of the accident contracts carry a medical expense rider. This is a comprehensive type of coverage in that there are no limitations; it pays the doctor, nurses, hospital bills and any charge within reason.

Group Accident and Sickness Coverage

There are a few companies which issue a contract with a deductible and co-insurance clause to the group. In the group, there is very little underwriting and no attention is paid to pre-existing illnesses when the initial contract is written. New registrants in the group are handled in two ways. An employee who is new with the company has 30 days to join the group, and if he elects to do so, within this period, there is no underwriting. If he elects to pass up this group coverage and decides six months later that he does want in the group, underwriting and pre-existing diseases come into place. If, however, all information is given on the application and the registrant is taken into the group, as long as all is admitted on the application, pre-existing or not, he is covered.

Underwriting in Individual Accident and Sickness Contracts

Individual accident and sickness contracts are a different story because we are dealing with an underwriting problem. Each contract has to be strictly underwritten because we have to know about any pre-existing conditions at the beginning stage of the individual contract. Most contracts, however, have a two year period in which the company has to get off the risks, and after that fraud must be proved. So, in general, I think I can safely say that practically every company issuing this type of contract can recognize all claims after the policy has been in force two years, whether it is pre-existing or not.

The Over Sixty-Five Problem

We are asked the question, "What is being done for the Over 65?" I have just returned from an emergency meeting of the Health Insurance Association in New York which was called to come up with some answers which the Congress is going to ask us when it convenes. One of the questions we know will be asked is what are you going to do with the over 65? First of all, I can tell you what is already being done. A survey was made last year of all employed people over 65, and it was found that 43 per cent of them were covered. That is our answer at the moment as to what is being done . . . . but that still is not enough. The average individual who is over 65 and retired can purchase individual insurance for hospital and surgical protection. Even impaired risks can now purchase this type of insurance because there are at least seven carriers at the moment which are offering this type of coverage at what we call a substandard rate. When we speak of the uninsurable person, we mean the cardiac, the cancer victim, the bad ones that have been declined before. A resolution was passed at the meeting in New York whereby practically every major carrier in the country is going to try to supply these needs.

Conversions

Another question asked by the government is what do we do with a person who is trying to convert his policy to an individual policy when he leaves his employ. Today most of the contracts issued by the industry on a group basis are set up so that an individual can convert his group policy to an individual contract. Most of them are straight conversions; some are modified.

Growth of Health Insurance

I should like to quote a few figures that indicate the growth of health insurance in the last four or five years. Between December 1952 and

December 1956, there was a 27.5 per cent increase of people covered in all plans. The increase for surgical expenses was 39.89 per cent for all insurance, and for regular medical expense, the increase was 81.09 per cent. In contrast, the population increased only 8.02 per cent . . . . so we are making progress. Actual benefits paid for hospital and surgical expenses by health plans for this period amounted to 74.07 per cent for all insurors. The private insurance mechanism paid various types of benefits in excess of $1,000,000,000 used in whole or part for the payment of cost of medical care in 1956. Incidentally, that figure is about the same as a Social Security Administration survey figured the total for medical care would be.

We believe the insurance industry as a whole has made much progress, but it may be too little and too late. We must do much more in the next year or two or we will all be working for Uncle Sam.

Dr. Jere W. Annis, President of the Florida Medical Association, then introduced Dr. Duncan T. McEwan, Chairman of the Association's Committee on Commercial Health Insurance.

Program of the F.M.A. Committee on Commercial Health Insurance

DUNCAN T. MCEWAN, M.D.
ORLANDO

Our first committee meeting adjourned in time to get over here, and we did not quite complete all that we wanted to do. I prepared ahead of time what our program is going to be, but I have more general ideas now because our committee has met and we have discussed some of our problems.

First, I think we might consider why this state committee was formed. This committee came about because the private insurance industry became alarmed. It was afraid that the cost of private insurance was going out of bounds and would result in the government going into the health insurance business and socialization would come. A year ago last August a Medical Council of the insurance companies was formed and met with the Trustees of the American Medical Association to discuss the problem. They thought that all parties should get together and so they made the first move at the national level. They found that the medical profession realizes the need and

POST GRADUATE SEMINAR
DEPARTMENT OF SURGERY
UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

April 30 and May 1, 1959
Second Floor—Central Building
Jackson Memorial Hospital—Miami 36, Florida

PROGRAM

April 30, 1959

9:00 a.m. Welcome and Opening Remarks; Jay F. W. Pearson, Ph.D., President, University of Miami

9:30 a.m. Selection of Patients for Mitral Commissurotomy with Discussion of Results: Robert S. Litwak, M.D.

10:20 a.m. Management of Acute Head Injuries: David Reynolds, M.D.

11:15 a.m. Current Status of Tonsil and Adenoid Surgery: J. Ryan Chandler, M.D.

12:15 p.m. Lunch

1:30 p.m. The Treatment of Colles Fractures: Wallace Miller, M.D.

2:10 p.m. Indications for Surgery in Peptic Ulcer: Frank T. Kurzweg, M.D.

3:15 p.m. Ward Rounds

May 1, 1959

8:00 a.m. Fluid and Electrolyte Balance: Its Clinical Application: John J. Farrell, M.D.

8:50 a.m. Clinical Evaluation of Patients, with Arterial Insufficiency: John J. Fomon, M.D.

9:50 a.m. Treatment of Eye Emergencies: Edward R. Norton, M.D.

10:45 a.m. The Use of Adjuvant Chemotherapy for the Treatment of Cancer: Daniel S. Martin, M.D.

11:30 a.m. Selection of Treatment for Patients with Carcinoma of the Prostate: George R. Prout, M.D.

12:30 p.m. Lunch

1:45 p.m. Evaluation of Patients with Low Back Pain: A. Sarmiento, M.D.

2:30 p.m. Detection of Deafness in Children: O. J. Menzel, Ph.D.

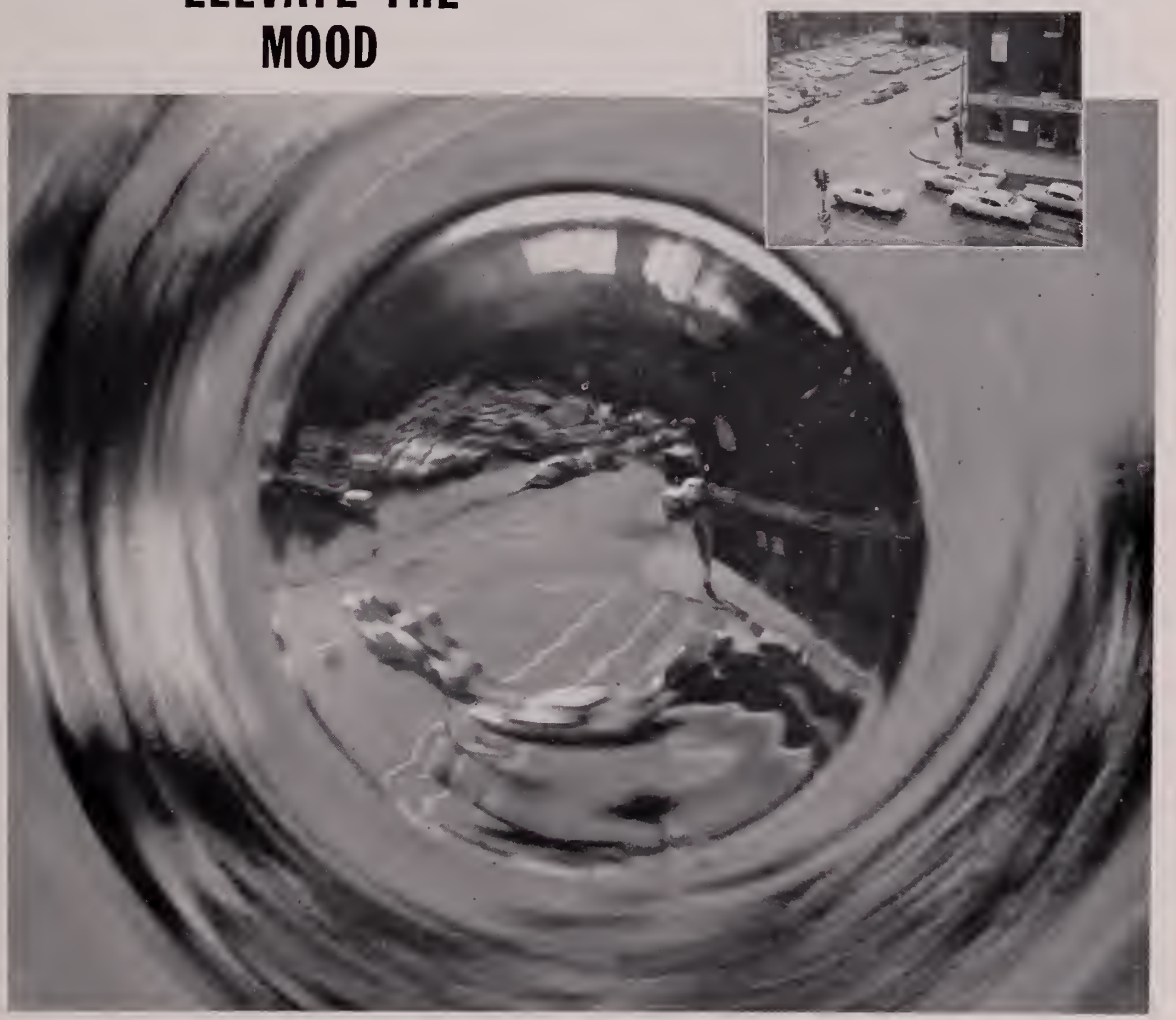
3:40 p.m. Laboratory Demonstration:
I. Open Heart Surgery
II. Cancer Chemotherapy

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University of Miami School of Medicine
Jackson Memorial Hospital
Miami 36, Florida

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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Research in the Service of Medicine **SEARLE**

was anxious to do something about it. Then came the formation of Medical Insurance Councils in the various states, and one was formed here in Florida. The Florida Insurance Council, headed by Dr. Paul R. Reinartz, of Prudential Insurance Company, wrote Dr. Annis and indicated that it wanted to cooperate with the Florida Medical Association and was in hopes that a committee could be formed with which it could cooperate. The Board of Governors therefore formed this committee of which I became Chairman.

I think that our first objective is to try to understand each other and I think that it is the main function of this committee. Dr. Wilhelm has talked about fees of $5,000 that some doctors were charging for an operation, and I have heard in the insurance industry of the misuse the doctors were making of the major medical plans. I have heard that many times when a doctor who usually charges a few hundred dollars for an operation finds that the patient has major medical expense protection, he has doubled, tripled, or quadrupled his fee. As a result, many of the major companies are alarmed, and it seems that one of the most alarming areas is Florida. They think that if the doctors continue to abuse the system of major medical plans, the companies will have to go out of business and have to do away with major medical coverage. I think we should try to impress upon the doctors that the insurance companies must collect premiums to pay us. If we are going to be unreasonable in our charges, insurance premiums are going to go up so high that the people will not be able to afford them and the companies will have to get out of that type of business, which will leave it wide open for the government.

I attended the local insurance council meeting in Jacksonville a few weeks ago. I listened to the members as they told me how much they thought the doctors should know and what they should do and I said, "Well, gentlemen, to me the insurance companies have a lot to learn and a lot of reforms to be made, and I think that we are going to have a lot of things to tell you so that you can help this problem, too." They had not thought so much of this, but they thought that it was a good idea. As I see it, our committee must act as a liaison with private insurance companies, telling them what we think they can do and explaining to the profession what insurance can do.

We realize that there are only a small number of doctors who indulge in abuses. We also realize that some of the insurance companies are respon-

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2. "Fevers of Unknown Origin"
3. "The Treatment of Pyelonephritis"

David L. Drabkin, M.D., Professor and Chairman, Dept. of Biochemistry, Univ. of Pennsylvania Graduate School of Medicine
1. "Present Status of the Problem of the Porphyrias"
2. "Inherent Functional Disabilities—Relative Excretory Inability for Iron, and Problems of Sideropenia and Cytosiderosis"
3. "Inherent Functional Disabilities—Relative Excretory Inability for Uric Acid, and Problem of Gout"

John B. Hickam, M.D., Chairman, Dept. of Medicine, Indiana Univ. Medical Center
1. "Advances in the Evaluation of Pulmonary Function"
2. "The Circulation of the Optic Fundus in Cardiovascular Disorders, as Observed by a New Method"
3. "New Data in the Field of Pulmonary Failure and Cor Pulmonale"

Joseph E. Murray, M.D., Clinical Associate in Surgery, Harvard Univ. School of Medicine and Massachusetts General Hospital
1. "Facial Fractures and Deformities"
2. "Organ and Tissue Homotransplantation"—Physiological and Immunologic Considerations—Part I
3. "Organ and Tissue Homotransplantation"—Surgical Considerations—Part II

Maurice N. Richter, M.D., Professor and Chairman, Dept. of Pathology, Postgraduate Hospital, New York City
1. "Interrelationships of the Lymphomas"
2. "Pathology of Hypersplenism"
3. "Indications for Splenectomy from the Standpoint of Splenic Pathology"

A. Earl Walker, M.D., Professor of Neurosurgery, The Johns Hopkins University
1. "Surgical Experiences in and About the Brain Stem"
2. "Neurosurgical Approach to Intractable Meniere's Syndrome"
3. "Surgical Consideration of Neck Pain"

Paul Wood, O.B.E., M.D., F.R.C.P., Director, Institute of Cardiology, London; Physician to the National Heart Hospital and Brompton Hospital, London
1. "The Physiological Basis of Physical Signs"—Part I
2. "The Physiological Basis of Physical Signs"—Part II
3. "The Venous Pulse"—(movie)
4. "Pulmonary Hypertension"

Symposia

(1) "The Problem of Antibiotic Resistant Infections"
Jerome Benson, M.D., Moderator
N. Joel Ehrenkrantz, M.D.
Ivan L. Bennett Jr., M.D.

(2) "New Concepts of Burn Therapy"
Richard M. Fleming, M.D., Moderator
Joseph E. Murray, M.D.
David L. Drabkin, M.D.
Ivan L. Bennett Jr., M.D.
Daniel S. Martin, M.D.

(3) "Congestive Failure"
David A. Nathan, M.D., Moderator
Paul Wood, M.D.
John B. Hickam, M.D.
David L. Drabkin, M.D.

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1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.

2. In elderly patients, initial dose 250 mg. (1 tablet) daily.

3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

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1. If patient is taking 40 or less units of insulin daily and gives no history of severe or "brittle" diabetic response, discontinue insulin and replace with DIABINESE as in The New Patient.

2. Complete control period as for The New Patient. Priming ("loading") doses should not be used.

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sible for urging doctors to make dishonest reports, give wrong dates and other things. We also believe that it is the responsibility of the county medical societies and the state medical society to deal with these abuses as they see fit. Many of the insurance companies have ignored abuses because they have not known what to do about them, but I think it is up to the medical profession itself to weed out these abuses and do something about them. We must take action against doctors who have made deliberate frauds against insurance before the insurance companies undertake legal means to prosecute them.

We hope that we will get the cooperation of all you gentlemen here today, and we hope that we will get the cooperation of the county medical societies, and we are sure that we will. I think that you realize, as we realize, that we are getting to the point where the government is about to take us over and we must keep working together with Blue Cross and Blue Shield and the private insurance companies to ward off this calamity. It is only by this cooperation that we can do it, and it is the purpose of our committee to try to cooperate with all concerned in this respect.

DR. ANNIS: Thank you, Duncan, and I am sure you all realize that if we are to do anything at all to prevent health legislation, it will be only insofar as we are ready to make some sacrifices in this regard.

Now as the anchor man for the afternoon, the gentleman who probably knows more, certainly about Blue Shield claims and the idiosyncrasies of the doctors involved, than anyone else in the state, and more about the state organization, Dr. Day, the new President of the Duval County Medical Association and the Secretary-Treasurer of the Florida Medical Association.

Blue Shield - Blue Cross Claims Committee Problems

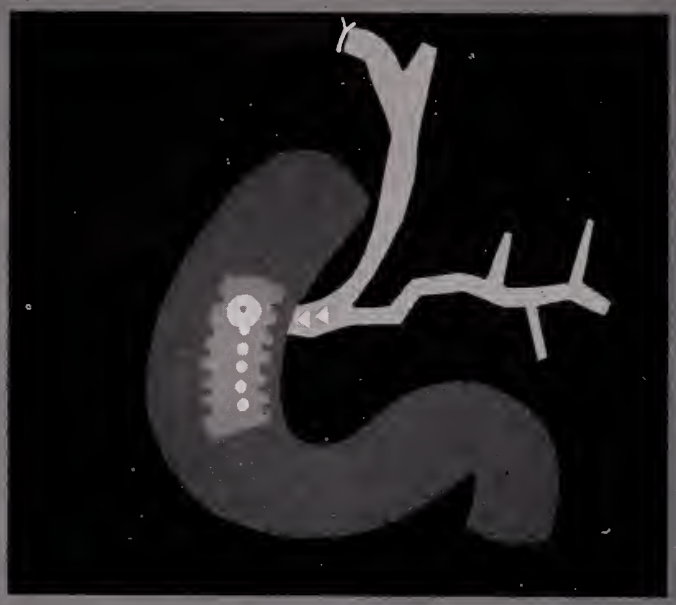
SAMUEL M. DAY, M.D.
MEDICAL CONSULTANT, BLUE SHIELD OF FLORIDA
JACKSONVILLE

I dislike to dwell on such a subject as abuse, but the problems arising from it are of such importance that I feel very definitely that they should be dwelled upon. Certainly you have heard a great deal about this subject already. Some of you have heard much of it from me. I apologize for repeating myself, but I am trying to reach more and more doctors.

The Claims Committee has been severe in judging diagnostic admissions and pre-existing

(Continued on page 1192)

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Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

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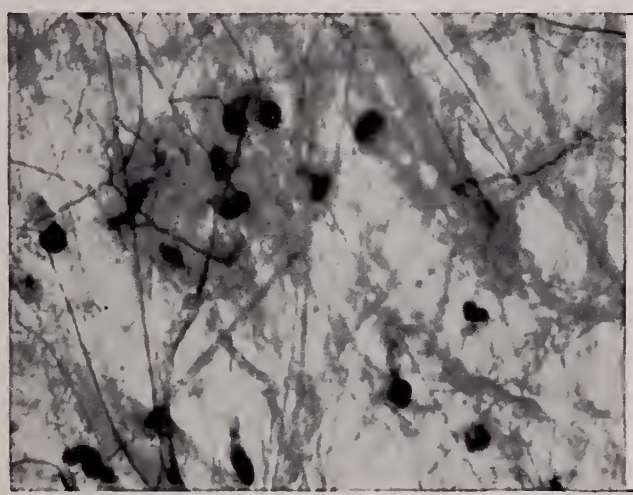
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(Continued from page 1188)

Table 1. — Blue Cross Rejection Study for Three Year Period

	1955		1956		1957	
Total cases processed	72,678		92,450		108,042	
Total cases rejected	3,126		4,729		5,430	
	DA	PE	DA	PE	DA	PE
Total cases rejected	169	741	350	1175	1036	1221
Per cent of rejected cases to total processed	0.2%	1.02%	0.4%	1.3%	1.0%	1.13%
Per cent of rejected cases to total rejections	5.4%	23.7%	7.4%	24.8%	19.1%	22.5%
Net gain or loss for year	401,000		117,000		373,000	
Per cent gain or loss for year	Gain 4.8%		Loss 1.1%		Gain 2.7%	

condition cases. We thought that we might be hurting Blue Shield public relations, but we also thought if these cases were not judged fairly, it could mean the destruction of Blue Shield and Blue Cross. The Blue Shield Board asked us just how much the actual cost was. The members wondered if it might not be better to pay in these cases and charge the cost to public relations. We did not know the answer; so we asked Mr. N. G. Johnson, our able man in charge of claims, to have his staff study the matter and bring out the facts. They prepared tables 1 to 4 and brought out some interesting facts.

(Dr. Day then discussed the tables in detail).

Table 2. — Blue Cross Rejection and Disapproval Statistics for 1957 By Code, Reason and Number For the Year Total — 5,430

Code	Reason	Amount
1.	Contract cancelled by subscriber	25
2.	Diagnostic admission	1,036
3.	Workmen's Compensation (occupational injury)	271
4.	Pre-existing condition	1,221
5.	Waiting period—Obstetrical Care—9 mos. or 12 mos.	380
6.	Waiting period—Tonsillectomy and Adenoidectomy—1 yr.	34
7.	Waiting period—Hernia—1 yr.	14
8.	Waiting period—Hemorrhoidectomy—1 yr.	7
9.	Patient not 14 days old	22
10.	Patient over age	63
11.	Patient not covered on contract	309
12.	Prior to effective date	99
13.	Single contract—OB	134
14.	Maximum OB coverage used	178







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15. Maximum days used in contract year	259
16. Maximum days used for this diagnosis (TB and Mental)	23
17. Not result of an accident	745
18. Not within 24 hours of an accident	165
19. Not initial Emergency Treatment	27
20. Outpatient x-ray	100
21. Not inpatient 6 hours	88
22. Not accredited hospital	67
23. Other	51
24. Not our subscriber	112
TOTAL REJECTIONS	5,430

Table 3. — Diagnostic Rejections—1957

Average number of claims received per month	8,551
Average number of diagnostic cases rejected per month	86
Average per cent of cases received per month rejected on basis of diagnostic admissions	1.05%
Average cost per case for diagnostic cases	$87.51
Number of diagnostic cases rejected in 1957	1,036
The approximate cost of the cases admitted, reported, and rejected, 1957	$90,660.36

Table 4. — Blue Cross Rejection Statistics for August 1958 Special Study

Total admissions	12,818
Total cases questioned	1,404
Per cent of total cases questioned	11.0%
Total questioned cases	1,404
Total rejected	610
Per cent of questioned cases rejected	43%
Total cases rejected	610
Total diagnostic cases referred to Claims Committee	129
Per cent of rejections reviewed by Claims Committee	21%
Total diagnostic cases reviewed by Claims Committee	129
Total diagnostic cases rejected by Claims Committee	76
Per cent of reviewed cases rejected by Claims Committee	59%
Total diagnostic cases rejected by Claims Committee	76
Total rejections contested by patient or doctor and resubmitted to Claims Committee	11
Per cent of rejections contested	15%

We have two major problems in administering our present contracts. The first is the problem of 'pre-existing conditions.' Some of our contracts say that during the first nine months after the effective date of the contract no coverage is allowed for conditions originating or existing prior to that effective date. This provision does not mean that the patient has to know about the condition, and the decision is therefore a difficult one. We cannot judge on the basis of whether or not the doctor or the patient knew

(Continued on page 1203)



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REDISOL is crystalline vitamin B_{12}, an essential vitamin for growth and the fundamental metabolic processes.

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Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

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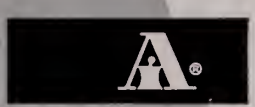
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HYDRODIURIL*

HYDROCHLOROTHIAZIDE

a new measure of activity



in edema

whenever there is need for diuresis

in hypertension

effective by itself in some patients—always as background medication in any antihypertensive regimen.

summary of clinical information—HYDRODIURIL (HYDROCHLOROTHIAZIDE)

IN EDEMA:

- greater oral effectiveness than with any other class of diuretic agent
- diuretic effectiveness maintained even on prolonged daily administration
- 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who did not respond satisfactorily to other diuretics
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restrictions





HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- similar qualitatively to chlorothiazide but 10 to 12 times more potent
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

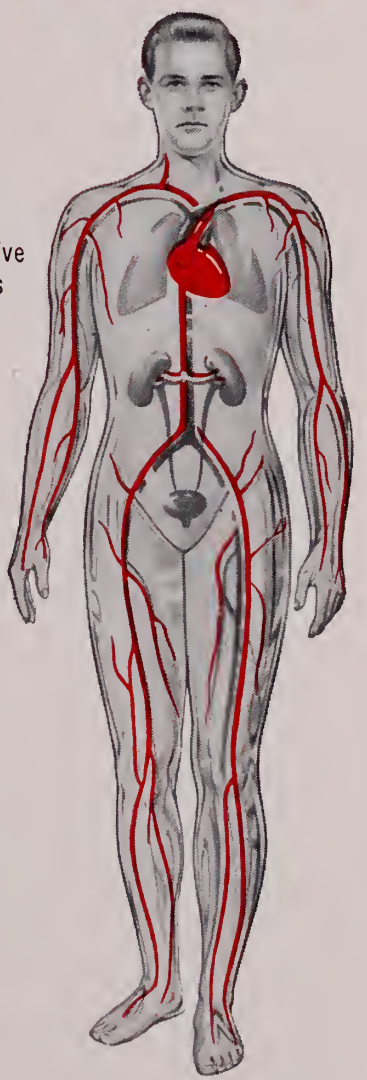
HYDROCHLOROTHIAZIDE

NEW RELEASE

IN HYPERTENSION:

- provides background therapy in any antihypertensive regimen (by itself, HYDRODIURIL adequately controls hypertension in some patients)
- has been reported by some investigators to have a greater antihypertensive effect in some patients than does chlorothiazide at equivalent dose levels
- does not lower blood pressure in normotensives
- markedly potentiates other antihypertensive agents
- reduces dosage requirements for other agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations





HYDRODIURIL*

HYDROCHLOROTHIAZIDE

NEW RELEASE





IS INDICATED IN:

1 Hypertension

2 Congestive heart failure of all degrees of severity

3 Premenstrual tension (edema)

4 Edema of pregnancy

5 Renal edema—nephrosis; nephritis

6 Cirrhosis with ascites

7 Drug-induced edema

8 as adjunctive therapy in the management of obesity complicated by edema

RECOMMENDED DOSAGE RANGE

In **EDEMA:** one to two 50 mg. tablets HYDRODIURIL once or twice a day

In **HYPERTENSION:** one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day. (When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.)

SUPPLIED as 25 mg. and 50 mg. scored tablets, in bottles of 100 and 1000.

PRECAUTIONS:

It is important that dosage be adjusted as frequently as the needs of the individual patient demand.

HYDRODIURIL has shown no adverse effects on renal function and is essentially not nephrotoxic; for this reason it may be used with excellent results even in patients for whom organomercurials are contraindicated because of renal damage. The excretion of potassium is much lower than that of sodium and chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, this potassium loss may be easily replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

Additional information on HYDRODIURIL is available on request.

BIBLIOGRAPHY:

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(Continued from page 1194)

of the condition, because, as you know, the patient can go to one doctor, learn of the condition, get the coverage and go to another doctor for treatment. We have had a number of cases in which the subscriber has been employed where coverage was available for years, but takes it out only after multiple opportunities and promptly tries to use it. This sometimes creates ill will, with subscribers and doctors, but we have the responsibility of protecting the funds which belong to a large number of persons. The pre-existing condition cannot be covered for much the same reason that you cannot buy fire insurance on a burning building.

The next most difficult problem is that of diagnostic admissions. The contract specifically states that we cannot pay for admissions primarily for diagnostic purposes. This situation reminds me of the orange juice stand that advertises "All you can drink for a dime." The operator offers the orange juice believing that the stomach has definite limitations. He gambles that he can furnish the orange juice to the average person and come out, but if someone used an artificial container and drained off the juice, the operator would go broke. Insurance is the same. You cannot pay for something which you have not figured on without facing the possibility of going broke. It is true that there are some things of a diagnostic nature that are covered, but the rates were figured with them in mind and not the strictly diagnostic admission to the hospital.

We try to evaluate possible diagnostic admissions from the records of the doctor and whether or not the patient could have been treated adequately in the office or other outpatient facilities. We have to have some standard that is fair to all and we bend over backwards to reach acceptable standards.

STATE NEWS ITEMS

Dr. Homer L. Pearson Jr. of Miami and Dr. Reuben B. Chrisman Jr. of Coral Gables have been appointed co-chairmen of the local Committee on Arrangements for the June meeting of the American Medical Association at Miami Beach.

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, will be the featured speaker at the annual meeting of the



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Medical Association of the State of Alabama being held April 9-11 at Birmingham. Dr. Orr's address "Medical Show Window of the World" will be delivered on the second day of the meeting.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, and Dr. William C. Roberts of Panama City, Immediate Past President, will be fraternal delegates from Florida at the annual meeting of the Medical Association of the State of Alabama being held April 9-11 at Birmingham.

Drs. Louis M. Orr of Orlando, Jere W. Annis of Lakeland, Samuel M. Day and Leo M. Wachtel of Jacksonville, Ralph W. Jack of Miami, Russell B. Carson of Fort Lauderdale and John S. Stewart of Ft. Myers were among the group of Florida physicians attending the Annual Blue Shield National Professional Relations Conference held in Chicago the first of February. Dr. Orr delivered the keynote address.

Dr. Hyman J. Roberts of West Palm Beach addressed the staff of the Memorial Hospital at Hollywood early in February. The subject of the presentation was "The Great Mimics in Modern Medical Practice."

Dr. Richard D. Shapiro of Miami Beach has been elected president of the Greater Miami Radiological Society. Dr. Andre S. Capi of Hollywood has been chosen vice president and Dr. George P. Daurelle of Miami secretary-treasurer.

Dr. M. Harlan Johnston of Jacksonville has been elected president of the North Florida Radiological Society and Dr. Paul A. Mori also of Jacksonville as secretary.

Dr. Lester L. Zipser of Tampa has been elected president of the Hillsborough County Chapter of the American Academy of General Practice. Dr. Marvin B. Miller has been chosen vice president and Dr. Warren T. Loftis Jr. treasurer. Drs. Miller and Loftis are also from Tampa.

Dr. Jere W. Annis of Lakeland, President of the Florida Medical Association, was guest speak-

(Continued on page 1214)



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HYDROXYZINE PAMOATE



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SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

PLUS

PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

VISTARIL•Capsules: *25 mg., 50 mg., 100 mg.*

VISTARIL Parenteral Solution: *10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).*

More than a tranquilizer

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In each enteric-coated tablet:

Hydrocortisone (alcohol) ..... 2.5 mg.
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Potassium para-aminobenzoate.. 0.3 Gm.
Ascorbic acid .....50.0 mg.

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*Using combined drug therapy with **PLAQUENIL®** or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

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nd of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

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Volume XLV
Number 10

SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.

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Your patient has a wide choice of unseasoned, strained or chopped foods

The Low Residue Diet

Consommé can be served jellied or hot. Puréed vegetables folded into well-beaten egg can be baked to a puff. Chopped beef moistened with broth and mixed with bread crumbs shapes into patties. Eggs can be soft or hard-cooked by simmering. Flaked fish in lemon gelatin looks true to nature when your patient uses a mold.

For banana-split salad he can try cottage cheese on banana and top with puréed apricots. Rice cooked in pineapple juice, water and sugar makes a golden dessert. For a parfait, try layers of farina pudding and puréed plums.

Of course, you'll tell your patient just which foods you want him to have—and whether he can enjoy a glass of beer* with his meals.

*pH—4.3, 104 Calories/8 oz. glass (Average of American Beers)

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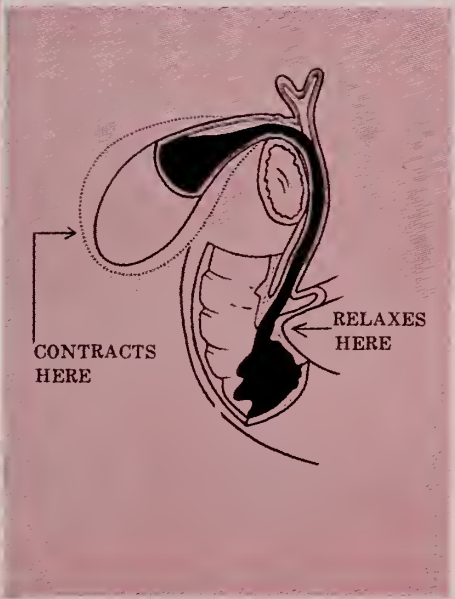
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<u>without</u> incompatibilities to antacids and other medications

Supply: Tablets, small and easy to swallow, in bottles of 100. Granules, cocoa-flavored, in 8 and 4 ounce canisters.

1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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(Continued from page 1204)

er at the recent meeting of the Tuberculosis and Health Association of Polk County held at Lakeland.

Dr. Jerome M. Greenhouse of Hollywood presented an exhibit on "Histopathology of Animal Skin Tumors" at the meeting of the American Academy of Dermatology and Syphilology held in Chicago.

A course in "Radiological Health for X-Ray Technicians" has been announced for July 6-10 at the Robert A. Taft Sanitary Engineering Center, 4676 Columbia Parkway, Cincinnati, Ohio. The course is sponsored by the Division of Radiological Health and the U. S. Department of Health, Education and Welfare. Information and application forms may be obtained from the Center. Communications should be marked "Attention: Training Program."

The Florida Trudeau Society is holding its annual meeting April 10-11 at The Colonnades Hotel, Riviera Beach, according to Dr. Kip G. Kelso of Vero Beach, president. Dr. Oscar Auerbach of the Veterans Administration Hospital, East Orange, N. J., will discuss "Bronchogenic Carcinoma and Lung Cancer." Additional specialists in various phases of diagnosis, treatment and surgery in the field of tuberculosis and related diseases will appear on the program. Dr. Charles F. Tate Jr. of Coral Gables is chairman of the program committee.

The American College of Chest Physicians will hold its Silver Anniversary meeting at the Ambassador Hotel in Atlantic City, June 3-7. The scientific program will include prominent speakers on all aspects of heart and lung diseases.

The Fifth Annual Surgery, Radiology, Pathology Symposium of the University of Oklahoma Medical Center will be held May 8-9 at the Medical Center in Oklahoma City. This year the symposium will be "Diagnosis and Treatment of Thyroid Diseases."

The Third Annual Post-Graduate Course in Fractures and Other Trauma is being presented by the Chicago Committee on Trauma of the

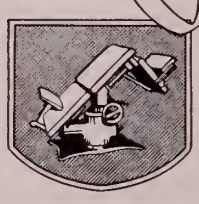


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strengthen bodies with needed protein
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l-Lysine	300 mg.
Vitamin B_{12}	25 mcgm.
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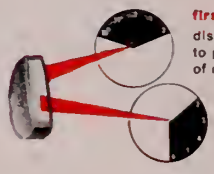
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- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



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Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

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American College of Surgeons April 15-18 at the John B. Murphy Memorial Auditorium, 50 East Erie St., Chicago.

A symposium on smoking and lung cancer and another on pulmonary emphysema will be among the highlights of the 54th annual meeting of the American Trudeau Society being held in Chicago May 25-28. All sessions will be at the Palmer House.

Physicians from Fort Myers participating in the First Annual Florida Medical Forum held at Fort Myers March 16-18 included Drs. Joseph L. Selden Jr., James L. Bradley, Joseph K. Isley, Frank M. Bryan, Gustave F. Bieber, H. Quillian Jones, Curtis R. House, John S. Stewart, Carey N. Barry, Roger D. Scott, Newton W. Larkum, Charles E. Peres Jr., Thomas M. Wiley Jr., and George D. Hopkins. Dr. Ralph S. Sappenfield of Miami, past president of the American Society of Anesthesiologists and the Southern Society of Anesthesiologists, appeared on the program to discuss "Anesthetic Factors in Maternal and Fetal Mortality."

The Forum was sponsored by the Lee, Charlotte, Hendry Medical Society, Dr. Wilson A. Rumberger, president, in cooperation with the Lee County Chamber of Commerce.

Dr. George H. Putnam of Gainesville, president of the Alachua County Medical Society, addressed a recent meeting of the University of Florida Chapter of the American Association of University Professors.

A five day seminar on "Care of Premature Infants" has been scheduled for May 18-22 at the Premature Demonstration Center, University of Miami School of Medicine, Jackson Memorial Hospital, Miami. Information may be obtained from the Bureau of Maternal and Child Health, Florida State Board of Health, Jacksonville.

Drs. Samuel A. Manalan and Irving B. Lees of West Palm Beach have appeared on the programs of recent meetings of the Miami Obstetrical and Gynecological Society. Dr. Manalan discussed "Granulosa Cell Tumor" and Dr. Lees "Carcinoma-in-Situ of the Uterine Cervix."



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Dr. Edward R. Woodward of Gainesville, Professor and Chairman of the Department of Surgery at the College of Medicine, University of Florida, presented a paper entitled "The Post-gastrectomy Syndrome - Its Prevention and Treatment" at the recent meeting of the American College of Surgeons held at Charleston, S. C.

Dr. G. Dekle Taylor of Jacksonville presented a paper on "The Otolaryngological Aspects of Skin and Scuba Diving" at the meeting of the Southern Section of the American Laryngological, Rhinological and Otological Society, held in Atlanta the latter part of January.

Dr. John D. Milton of Miami was among the group of physicians from Florida attending the annual meeting of the American College of Obstetricians and Gynecologists held April 6-8 at Atlantic City. Dr. Milton conducted one of the breakfast conferences.

Dr. Lawrence E. Geeslin of Jacksonville was principal speaker at the 12th annual homecoming for former patients of the Central Florida Tuberculosis Hospital at Orlando held the last of February.

Dr. Chas. McC. Gray of Tampa has been elected vice president of the American College of Radiology. He has just completed a four year term as a member of the Board of Chancellors of the College.

COMPONENT SOCIETY NOTES

Brevard

Drs. Duncan T. McEwan and Robert E. Zellner of Orlando were principal speakers on the program of the February meeting of the Brevard County Medical Society held at Cocoa Beach. Drs. McEwan and Zellner discussed insurance for the medical profession, Dr. McEwan from the aspect of private companies and Dr. Zellner from the Blue Shield approach.

Lake

Mr. Gordon Oldham, States Attorney, discussed expert witnesses and their fees at the February meeting of the Lake County Medical Society held at Clermont.

Monroe

Dr. A. W. Weinstein of Asbury Park, N. J., addressed the members of the Monroe County



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Medical Society at their February meeting. His subject concerned a new drug used in controlling obesity.

Orange

"Diseases of the Esophagus" was the subject of a paper read by Dr. Robert B. Trumbo of Orlando at the January meeting of the Orange County Medical Society. The program of the February meeting featured Dr. Joseph E. O'Malley of Orlando, who discussed "Facial Carcinoma."

Volusia

A forum on medical and legal problems was the feature of the February meeting of the Volusia County Medical Society. Members of the panel included Drs. Arthur Schwartz of Daytona Beach, Charles E. Tribble of DeLand, and attorneys Isham Wm. Adams and Alfred A. Green Jr.

Hillsborough — Pinellas

The annual joint meeting of the Hillsborough County Medical Association and the Pinellas County Medical Society was held March 2 at Clearwater. Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was principal speaker.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Daniel R. Usdin of Jacksonville announce the birth of a son, Mark Gerald, on Jan. 6, 1959.

Dr. and Mrs. James A. Cranford Jr. of Jacksonville announce the birth of a daughter, Stuart Bolling, on Feb. 6, 1959.

Mr. and Mrs. Dale Carson (Dr. Doris) announce the birth of a daughter, Cynthia Louise, on Jan. 18, 1959.

Deaths—Members

Alspach, Walter L., Miami	Feb. 11, 1959
Boone, J. Lunsford, Green Cove Springs	Feb. 15, 1959
Eichert, Herbert, Miami	Feb. 2, 1959
Failmezger, Theodore R., Clearwater	Feb. 7, 1959
Hughes, Robert L., Bartow	Jan. 6, 1959
Johnston, William C., W. Palm Beach	Feb. 24, 1959
Litterer, A. Buist, Miami	Jan. 1, 1959
McClosky, Ben. M., Tampa	Dec. 10, 1958
Rose, Joseph E., Pensacola	Dec. 28, 1958
Sher, David Daniel, Miami Beach	Dec. 12, 1958
Thomas, Efton Jewell, Miami Beach	Feb. 4, 1959
Thomas, Joseph E., Plant City	Dec. 31, 1958
Webb, Carol C., Pensacola	Dec. 29, 1958

Deaths—Other Doctors

Clarke, Eric K., Lynn Haven	Nov. 19, 1958
Corbett, Joseph H., Jasper	Jan. 26, 1959
Kerr, John C., St. Petersburg	Nov. 20, 1958
Yarbrough, Henry Charles, Green Cove Springs	Sept. 11, 1958



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Iodine (as KI)	0.1 mg.
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Phosphorus (as $CaHPO_4$)	122 mg
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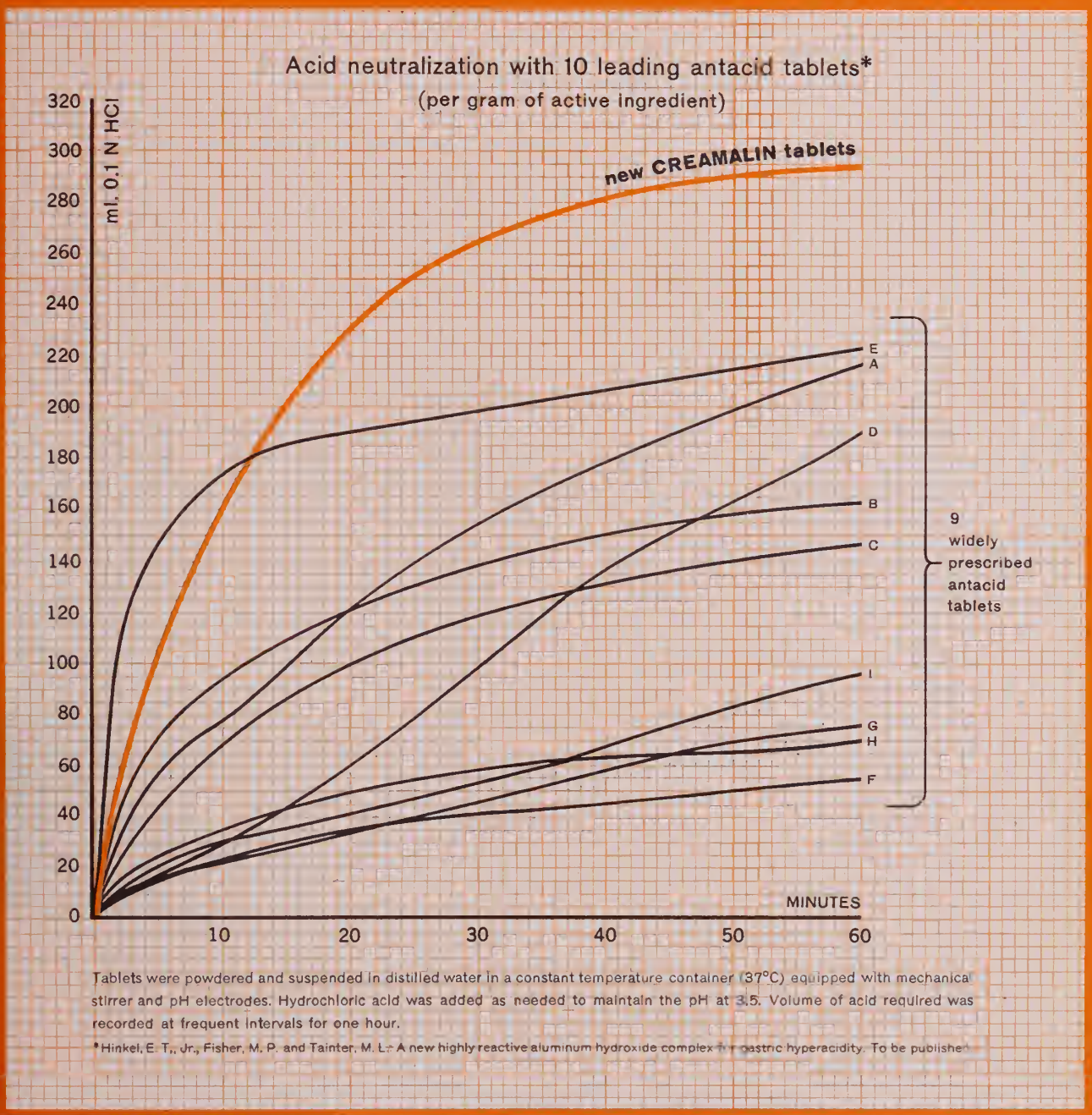
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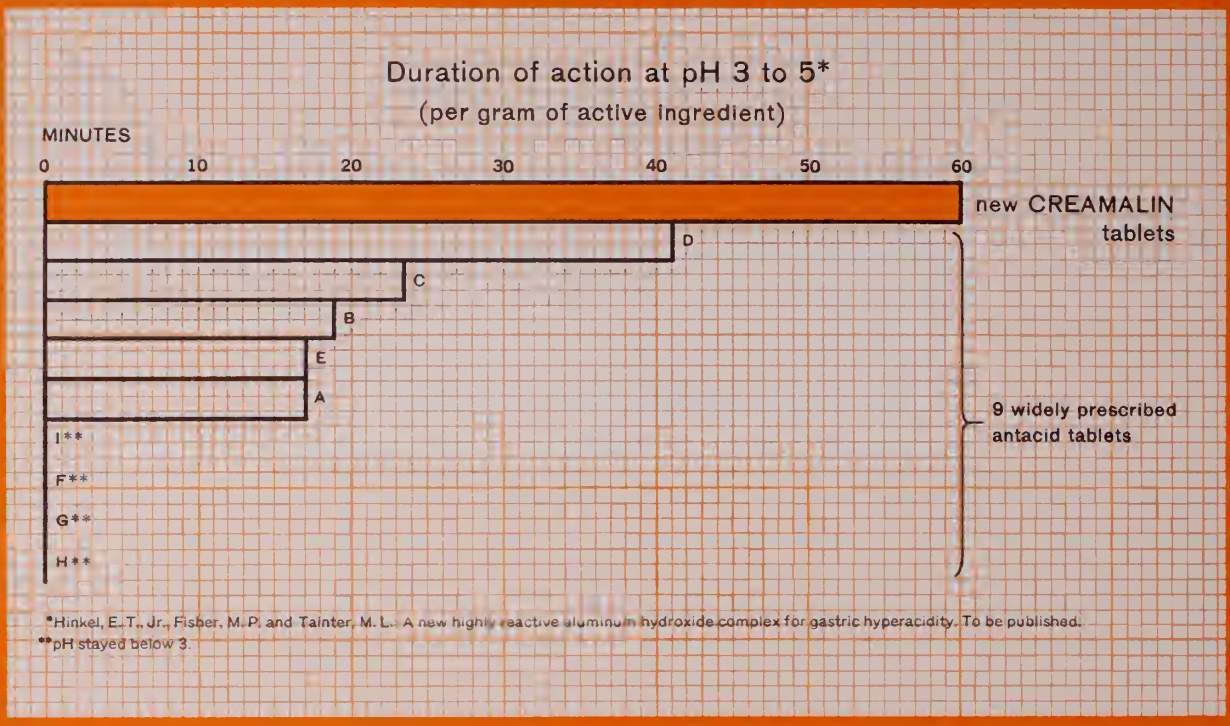


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*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published

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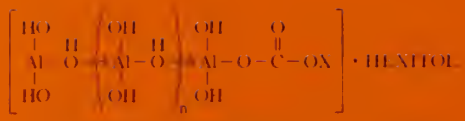
*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
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References: 1. Miller, J.H., et al.: Am. J. Dig. Dis. 3:229-231, 1958. 2. Swartzwelder, J. C., et al.: A.M.A. Arch. Int. Med. 101:658-61, 1958. 3. Frye, W. W., et al.: Am. J. Trop. Med. Hyg. 6:890-893, 1957. 4. Swartzwelder, J. C., et al.: J.A.M.A. 165:2063-67, 1957.

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OBITUARIES

Melton D. Council

Dr. Melton D. Council of Vero Beach died on Oct. 5, 1958, in McGuire Veterans Hospital in Richmond, Va. He was 74 years of age. Funeral services and interment took place in McRae, Ga.

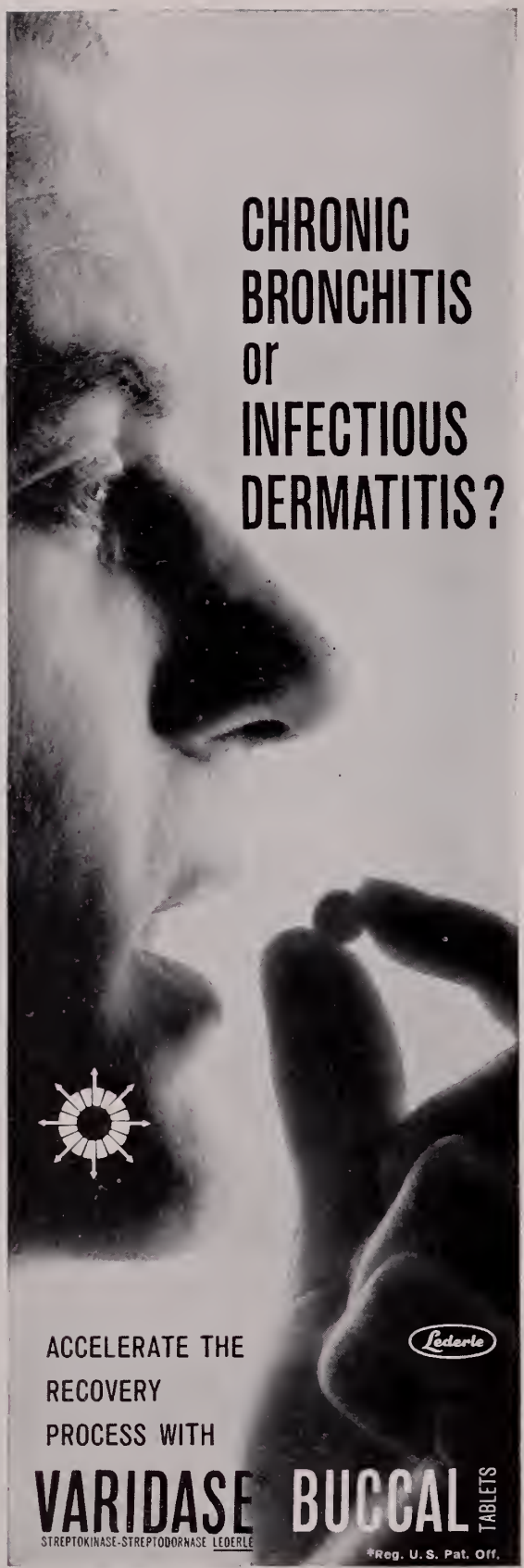
Born in McRae on Jan. 5, 1884, Dr. Council received his academic training at South Georgia College in McRae and at Emory University, where he was graduated in 1904. He attended the Johns Hopkins University School of Medicine for his medical training and was awarded the degree of Doctor of Medicine in 1911. He then entered the private practice of medicine in McRae. After serving as a captain in the Army Medical Corps during World War I, he returned to McRae to resume the practice of medicine and surgery.

In 1924, Dr. Council received his Florida state license and the following year located in Fort Pierce, practicing in the four counties of Martin, Okeechobee, St. Lucie and Indian River. For some time he was the only surgeon in the four counties. He served on the staff of Fort Pierce Memorial Hospital, Martin County Hospital in Stuart and Indian River Memorial Hospital in Vero Beach. In 1927, he moved to Vero Beach, maintaining offices there and in Fort Pierce until 1949, when he closed his Fort Pierce office. In 1951, he retired from active practice. Locally, he was a member of the First Methodist Church, a Mason and a Rotarian.

Dr. Council was a member of the Indian River County Medical Society and for 30 years had held membership in the Florida Medical Association. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Virginia Council of Vero Beach; a son, James Edwin Council of Charlotte, N. C.; two sisters, Mrs. Mae H. Suddath of Tampa, and Mrs. Fred A. Smith of McRae; and four brothers, K. K. Council of Macon, Ga.; James C. Council of Waycross, Ga.; John W. Council of Savannah, Ga., and Arthur Council of Tampa.

(Obituaries Continued on page 1230)



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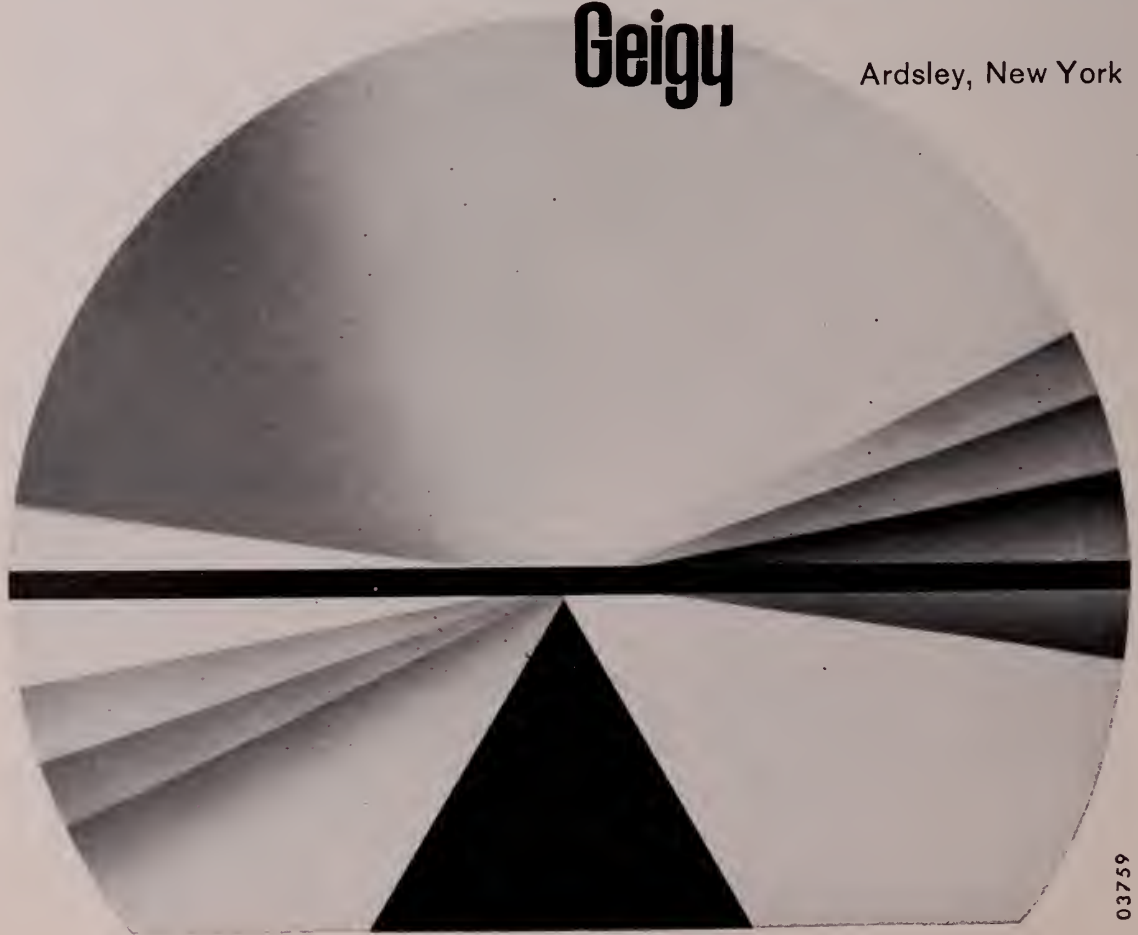
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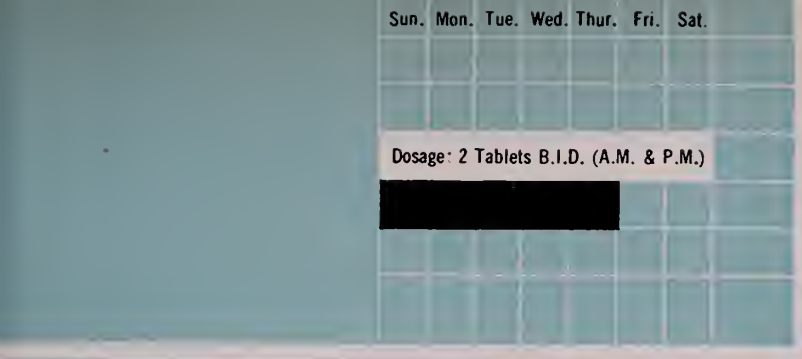
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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Samuel Aronovitz

Dr. Samuel Aronovitz of Miami died on Oct. 27, 1958. He was 71 years of age.

Having spent 45 years in the practice of medicine, Dr. Aronovitz was one of the oldest active practitioners in Dade County. Born in 1887, he was reared from infancy in Key West, where his father was a prominent merchant and president of the Synagogue. For his medical training he attended the College of Physicians and Surgeons of Baltimore and was awarded the degree of Doctor of Medicine in 1911. Two years later he received his Florida state license and returned to Key West to engage in the practice of medicine.

In 1924, Dr. Aronovitz located in Miami, where he continued through the years to practice internal medicine. He was one of the founders and the first president of the Sholem Lodge of B'nai B'rith, and was most active in Temple Israel. He participated in many of the charitable and civic affairs of the growing community.

Dr. Aronovitz was one of the early members of the Dade County Medical Association and was regularly an interested participant in its meetings. He had for nine years been a life member of the



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Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn



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Pearl River, New York

Florida Medical Association, having held membership in the Association for 44 years. He also held membership in the American Medical Association and societies of his specialty.

Surviving are the widow, Mrs. Millie Aronovitz, and a daughter, Mrs. Arline Kent, of Miami Beach; five brothers, including Isidore, Jack and Abe Aronovitz of Miami; and one grandchild.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Adler, Philip, Tampa
Anderson, Robert M., Sarasota
Boyle, Playford Jr., Sarasota
Boyles, Paul W., Miami
Boynton, Bruce II, Naples
Brooks, Beach A., Winter Haven
Evans, William C. Jr., Gainesville
Fishel, John L., Panama City
Haeck, Alfons J., Orlando
Hood, Claude I., Gainesville
Kitaif, James C., Palatka
Krans, DeHart, Tallahassee
Largen, Thomas L., Sanford
LeVine, Morris J., St. Petersburg
Maclure, John G., Miami
Maren, Thomas H., Gainesville
Marquardt, Robert G., Leesburg
Niswonger, Joseph K., Lakeland
Reynolds, Arthur M. Jr., Sarasota
Rosenbaum, Irving H., Sarasota
Sall, Walter G., Miami Beach
Sanders, Harold L., Tampa
Smith, Robert J., Sanford
Steele, Robert G., Sarasota
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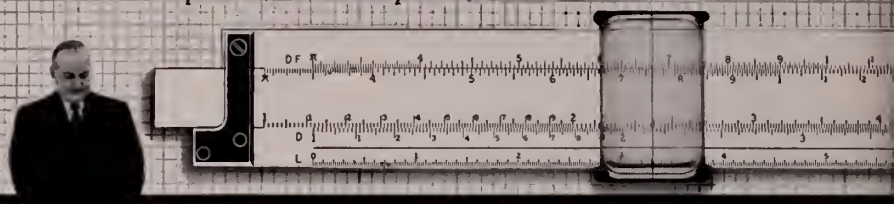
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Capsules / Oral Suspension

* designed for superior control of common Gram-positiv infections

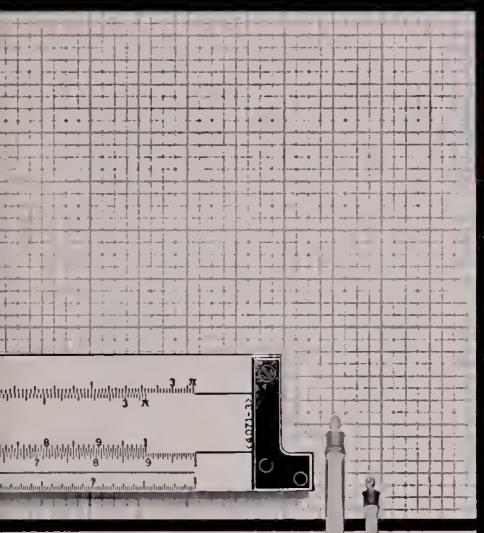


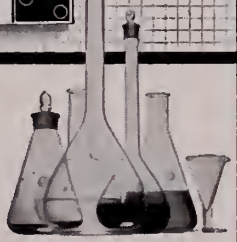


in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	**30**	**8**	**4**

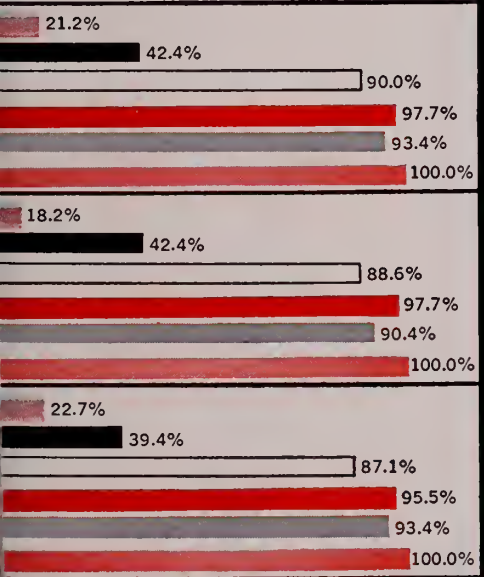




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90% effective
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TUBE DILUTION, CYLINDER PLATE)
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biotic A 2-10 units — Tao 2-15 mcg.
biotic B 5-30 mcg. — Antibiotic D 2-15 mcg.
biotic C 5-30 mcg. — Antibiotic E 5-30 mcg.

age of organisms inhibited by the range of
rations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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For children—flavorful, easy to administer.

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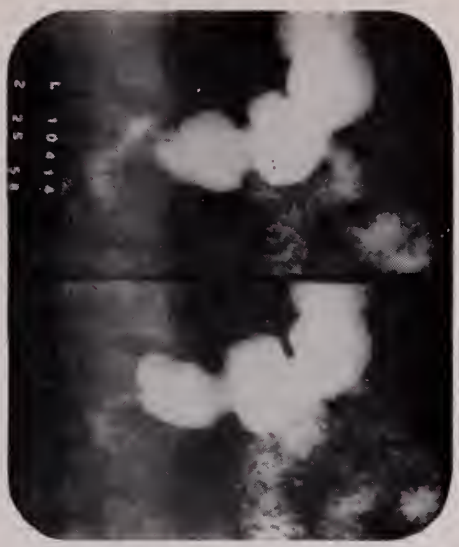
relieve the tension



nd control its G.I. sequelae



Patient A.S., age 53.
Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



PATHIBAMATE *(Tabs. j t.i.d. and H.S.);* prompt relief of symptoms. Radiograph (21 days later) confirms healing of minute lesser curvature gastric ulcer crater.

predictable results in the control of tension and G.I. trauma

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Meprobamate with PATHILON® Tridihexethyl Chloride* LEDERLE

Used prophylactically in anticipation of periods of emotional stress, or therapeutically to relieve tension and curb hypermotility and hypersecretion, PATHIBAMATE is particularly well-formulated for the control of gastrointestinal disorders.

AMATE **combines** Meprobamate (400 mg.) — the noted tranquilizer-muscle relaxant widely accepted for safe ment of tension and anxiety states — and PATHILON (25 mg.) — an extremely well-tolerated anticholinergic, ed for prompt symptomatic relief based on peripheral atropine-like action with few side effects.

ns:
l ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety with gastrointestinal symptoms, gastric hypermotility.

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f 100 and 1,000. Each tablet (yellow, ½-scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

tration and Dosage:
three times a day at mealtimes and 2 tablets at bedtime. Adjust dosage to patient response. Contraindicated in glaucoma, bstruction, and obstruction of the urinary bladder neck.

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Parenteral — 10 mg./cc. — 1 cc. ampuls;
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OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.
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POWDER: Shaker-top bottles of 10 Gm.



OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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Selective

Does not interfere with autonomic function
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ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."

(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.

(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

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Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE* (Miltown 200 mg. + PETN 10 mg.).

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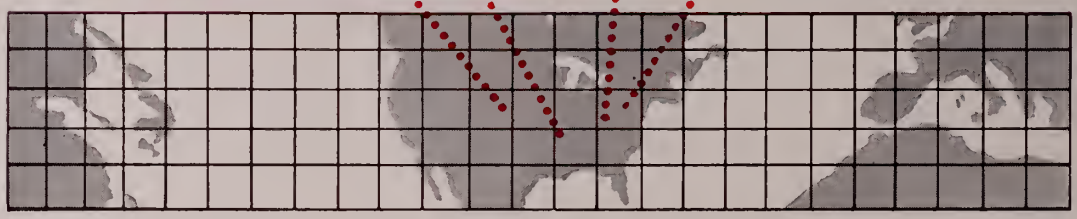
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior . . ."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety . . . its safety makes it an excellent drug for out patient use in office practice."[4]



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For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Pearl River, New York

BOOKS RECEIVED

The Physical Treatment of **Varicose Ulcers.** *A Practical Manual for the Physiotherapist and Nurse.* By R. Rowden Foote, F.I.C.S., M.R.C.S., L.R.C.P., D.R.C.O.G. Pp. 128. Price, $4.00. London, E. & S. Livingstone Ltd, 1958. (The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.)

This well illustrated little volume offers the physiotherapist and nurse a pocket-sized manual setting forth the essentials of massage and the elements of exercises as applied to the ulcerated limb. The author observes in the Preface that the majority of sufferers from varicose or venous ulcers can be made into useful pain-free citizens by the simplest of methods. While surgery holds its place in the treatment of resistant cases and in the eradication of basic causes, physiotherapy, compression treatment, and simple exercises will heal and keep healed the vast majority of ulcers. Furthermore, massage and movement are usually necessary as an antecedent to operation in order to prepare the field for the surgeon. Accordingly, he covers the subject in nine chapters dealing with the importance of the "varicose ulcer" problem, the anatomy and physiology of the venous systems of the leg, the common types of leg ulcers and their causes, the general principles in treatment and the role of the physiotherapist, the treatment of ulcers by compression, the technic of massage, physical exercises in treatment, adjuncts to regular treatment, and the aftercare of healed ulcers. A tenth chapter by Truda Wareham, M.C.S.P., Superintendent Physiotherapist, St. Bartholomew's Hospital, London, deals with electrical adjuncts to treatment.

Clinical Obstetrics and Gynecology; Volume 1, Number 3, **Symposium on Special Diagnostic Aids,** edited by C. Paul Hodgkinson, M.D., and **Symposium on Abnormal Uterine Bleeding,** edited by John I. Brewer, M.D. Pp. 549-852. Price, $18.00 by subscription for four consecutive numbers. New York, Paul B. Hoeber, Inc., 1958.

This third volume (September 1958) of a new quarterly book series follows the basic structure of two symposiums per issue. Only the newer tests of proved value are included in the compilation of aids to accurate obstetric and gynecologic diagnosis. These procedures are considered to be of value in the diagnosis of vague and poorly understood clinical conditions because that is where accuracy is most needed. In the continuing search for accuracy, the various tests and procedures herein described reflect in part the efforts of the modern obstetrician-gynecologist to eliminate uncertainty in today's diagnostic procedures. Among the contributors to the Symposium on Special Diagnostic Aids were Dr. James Henry Ferguson and Dr. Howard A. Novell of the faculty of the University of Miami School of Medicine, whose subject was "Placentography."

The Symposium on Abnormal Uterine Bleeding covered the causes, methods used in diagnosis, genital bleeding during infancy and childhood, management during the climacteric, postmenopausal bleeding, psychosomatic aspects of uterine bleeding and functional bleeding.

Essentials of Therapeutic Nutrition. By Solomon Garb, M.D. Pp. 147. Price, $2.00. New York, Springer Publishing Company, Inc., 1958.

Noting a fairly common attitude of indifference or aversion among graduate nurses to the subject of nutrition, the author observed that students in his classes showed real interest when the material on nutrition was discussed in terms of patients and diseases. These observations led him to write this book from the patient-centered rather than the food-centered viewpoint. In

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In addition to peptic ulcer, DARICON is also indicated for other gastrointestinal disorders characterized by hypersecretion, hypermotility and spasm (e.g., functional bowel syndrome, chronic nonspecific ulcerative colitis and biliary tract disease).

Dosage: 10 mg. b.i.d. (morning and evening). **Supply:** Tablets, 10 mg., white, scored. Bottles of 60 and 500.

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Napoleon exhibited ulcer symptoms through most of his adult life, yet he scorned medication for his everlasting "spasms of nervous origin." He ignored his infirmities with violent naïveté despite an intense interest in medical science. Thus, the classic hand-in-coat pose may have been the result of his paroxysms of gastric pain that sliced "like the stab of a penknife."

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frontal assault—If your tactics dictate Local Action, try ROBALATE,® which is dihydroxy aluminum aminoacetate (0.5 Gm. per tablet or 5 cc.), an antacid of definitely superior efficacy.

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Part 1, the basic principles of nutrition as they affect the patient are discussed. In Part 2, the therapeutic diets in commonest use in the United States are outlined, explained and analyzed; they represent the diets used in the leading hospitals throughout the country. In Part 3, quick reference tables are presented which should be of continuing assistance to the reader. Since the nurse, as a professional person, should understand the reasons for the therapeutic programs in which she participates, and should be aware of some of the differing opinions about these programs, an efforts is made to emphasize the "why" of the nutritional regimen. Recipes are omitted, and individual meal plans are not given for each therapeutic diet because the nurse who wishes to construct her own meal plans can easily do so from the data supplied in the book.

Cold Injury, Ground Type. Editor in Chief, Colonel John Boyd Coates, Jr., MC.; Associate Editor, Elizabeth M. McFetridge, M.A. By Colonel Tom F. Whayne, MC, USA (Ret.), and Michael E. DeBakey, M. D. Pp. 570. Price $6.25. Washington, D. C., Office of the Surgeon General, Department of the Army, 1958.

This is one of the most comprehensive volumes on the ground type of cold injury that has ever been published. If it is carefully studied, and if the lessons of the experience of the United States Army in World War II are properly taken into account, there should be no similar experience in any future war. The enormous public interest aroused in the incidence of cold injury during that war was well founded for the United States Army suffered more than 90,000 casualties from it. The losses occurred because the lessons of the past had not been learned. This book contains a complete historical account of the condition in all recorded wars, as well as complete chapters on the World War II experience of the United States Army in Alaska, Italy, the European

(Continued on page 1253)



provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
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Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

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(Continued from page 1245)

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Ciba Foundation Colloquia on Ageing, Volume 4, **Water and Electrolyte Metabolism in Relation to Age and Sex.** Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Maeve O'Connor, B.A. Pp. 327. Illus. 85. Price, $8.50. Boston, Little, Brown and Company, 1958.

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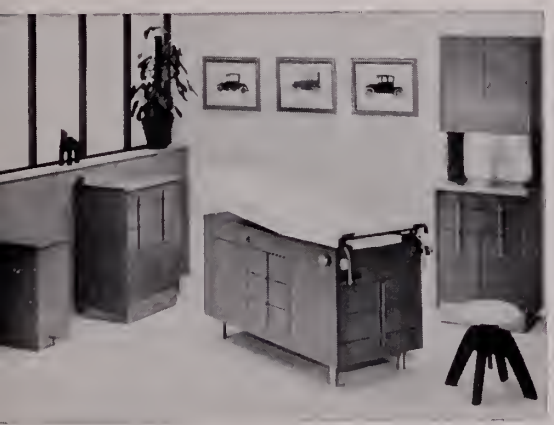
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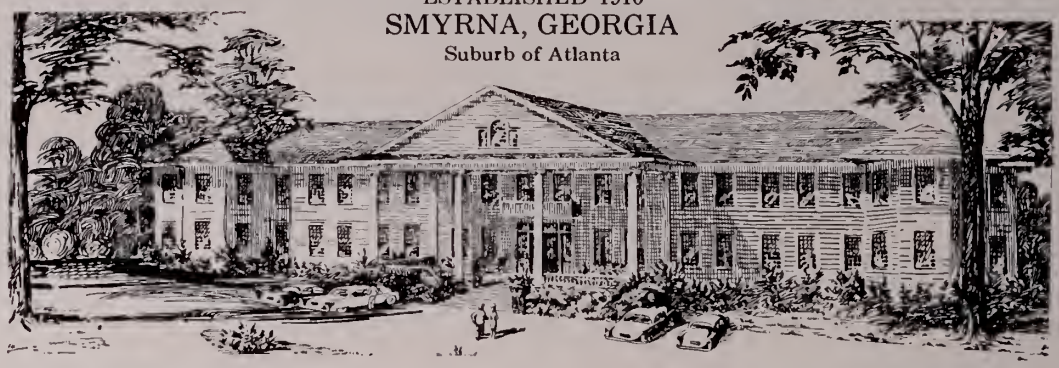
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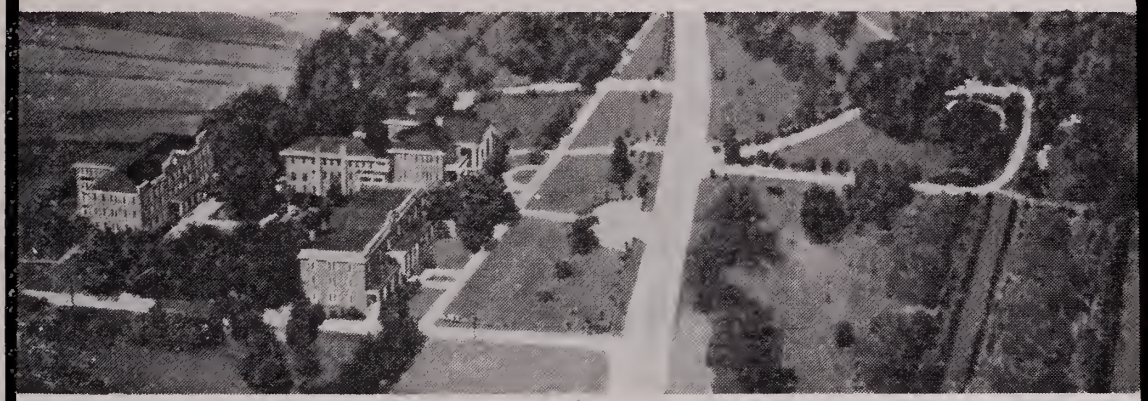
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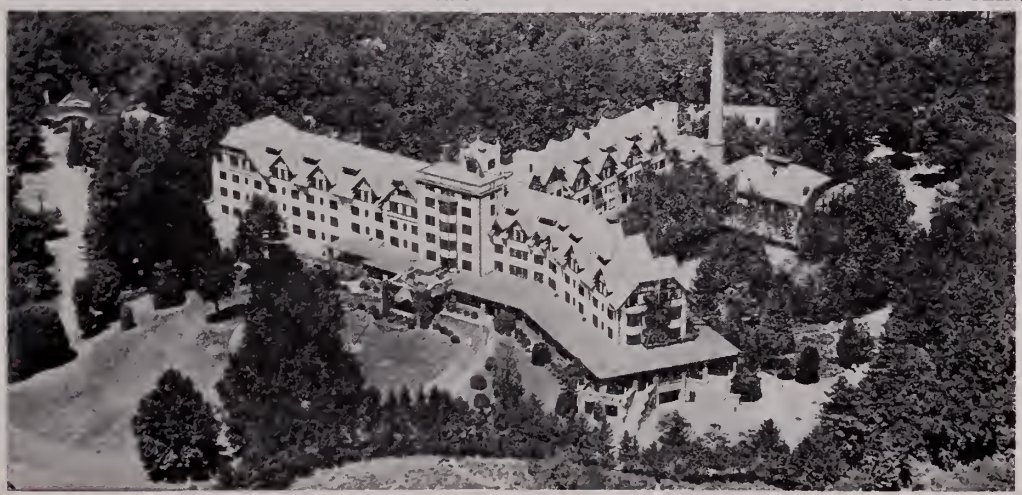
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	ACTIVE MEMBERS
Alachua	George H. Putnam, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	62
* *Bradford, Gilchrist, Union*				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	31
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	59
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	223
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	920
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	355
* *Clay*				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	115
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	234
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	29
* *Sumter*				
Lee-Charlotte-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	Quarterly	75
Madison	Thomas G. Bouland Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	33
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	36
* *Levy*				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	8
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	232
* *Osceola*				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	178
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	291
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	125
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	11
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Robert F. Mecko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	28
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	82
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	16
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	7
* *Dixie*				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	90
* *Flagler*				
Walton-Okaloosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	29
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	5
				3,465

* *Supervise and aid until organized separately.*

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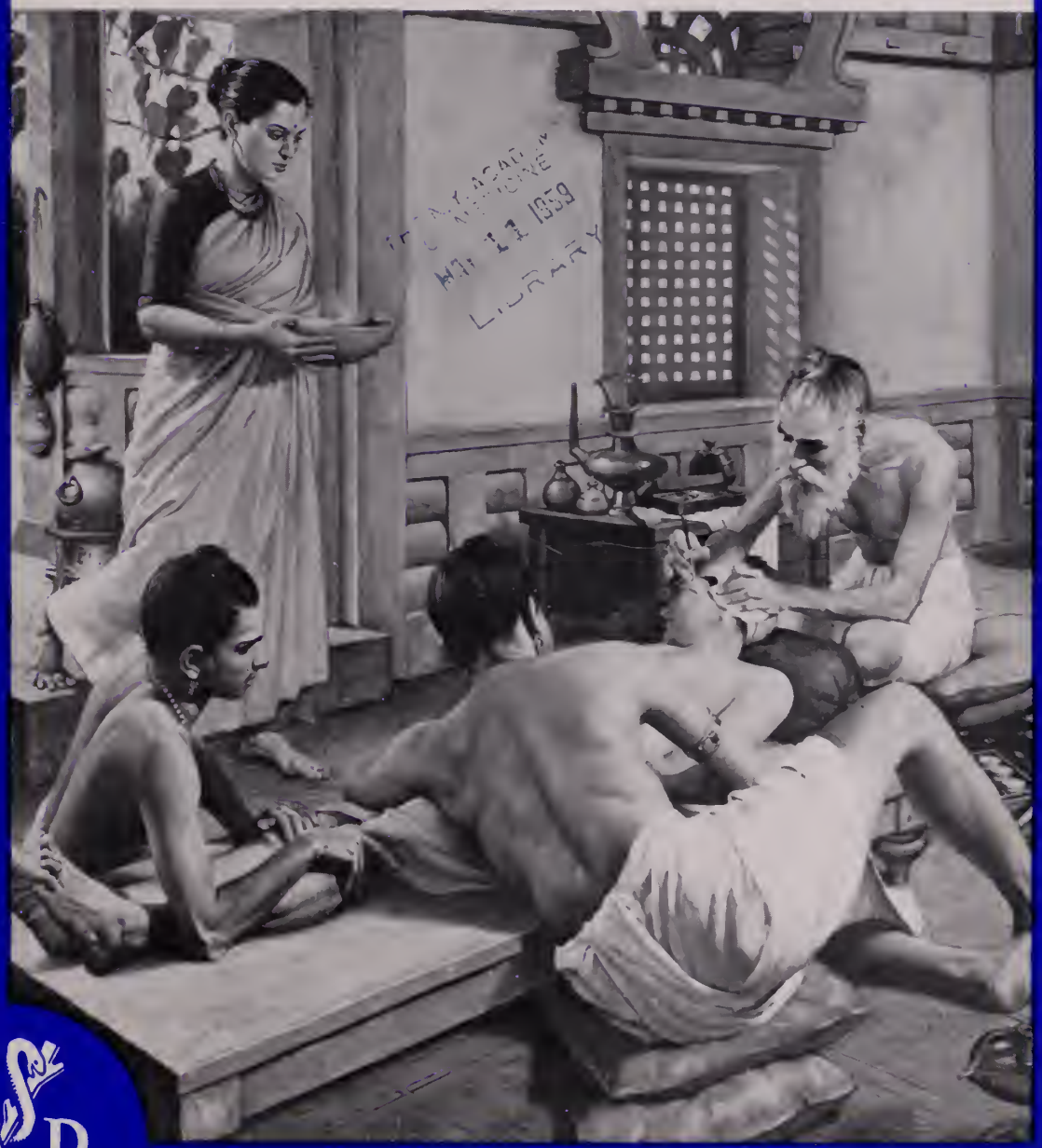
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effective anticonvulsants for most clinical ne

bibliography: (1) Carter, S. M.: *M. Clin. North America:* 315 (March) 1953. (2) Chao, D. H.: *Ibid.*, p. 465. (3 man, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, MacMillan Compan p. 187. (4) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1958, Philadelphia, W. B. Saunders C 1958, p. 568. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) French, E. G.; Rey-Bellet, J., & W. G.: *New England J. Med.* 258:892 (May 1) 1958.



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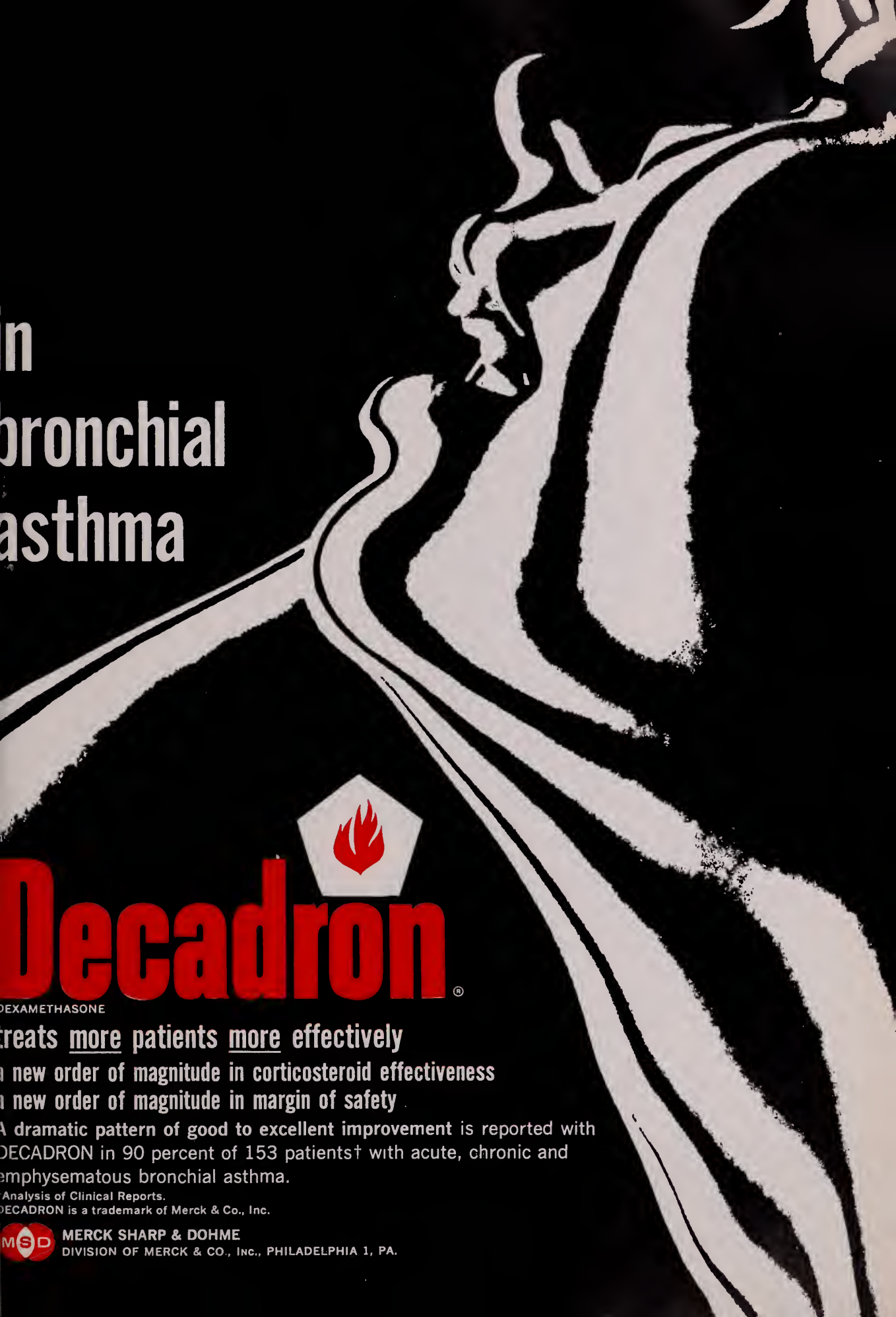
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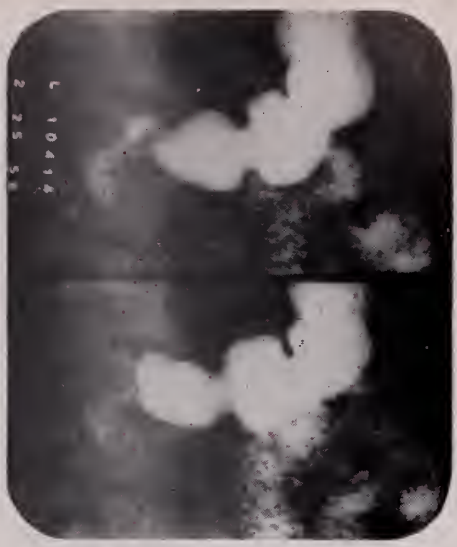
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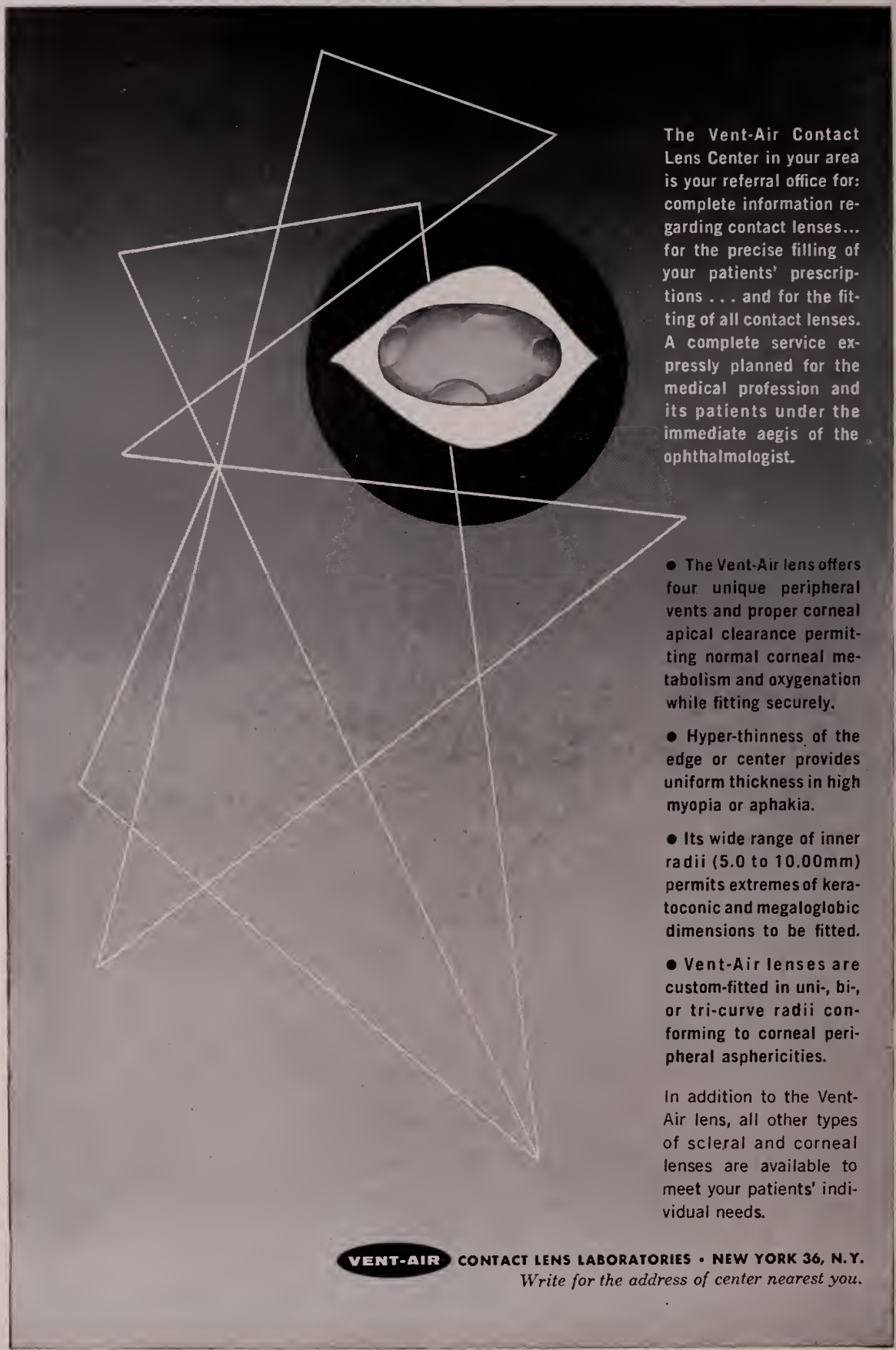
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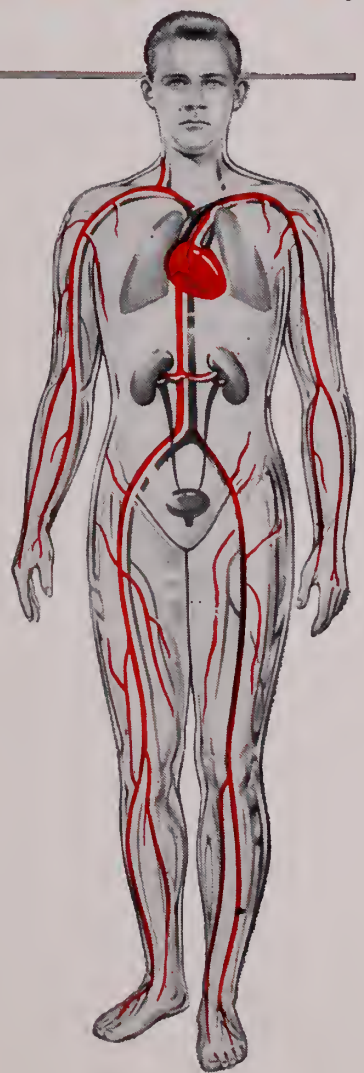
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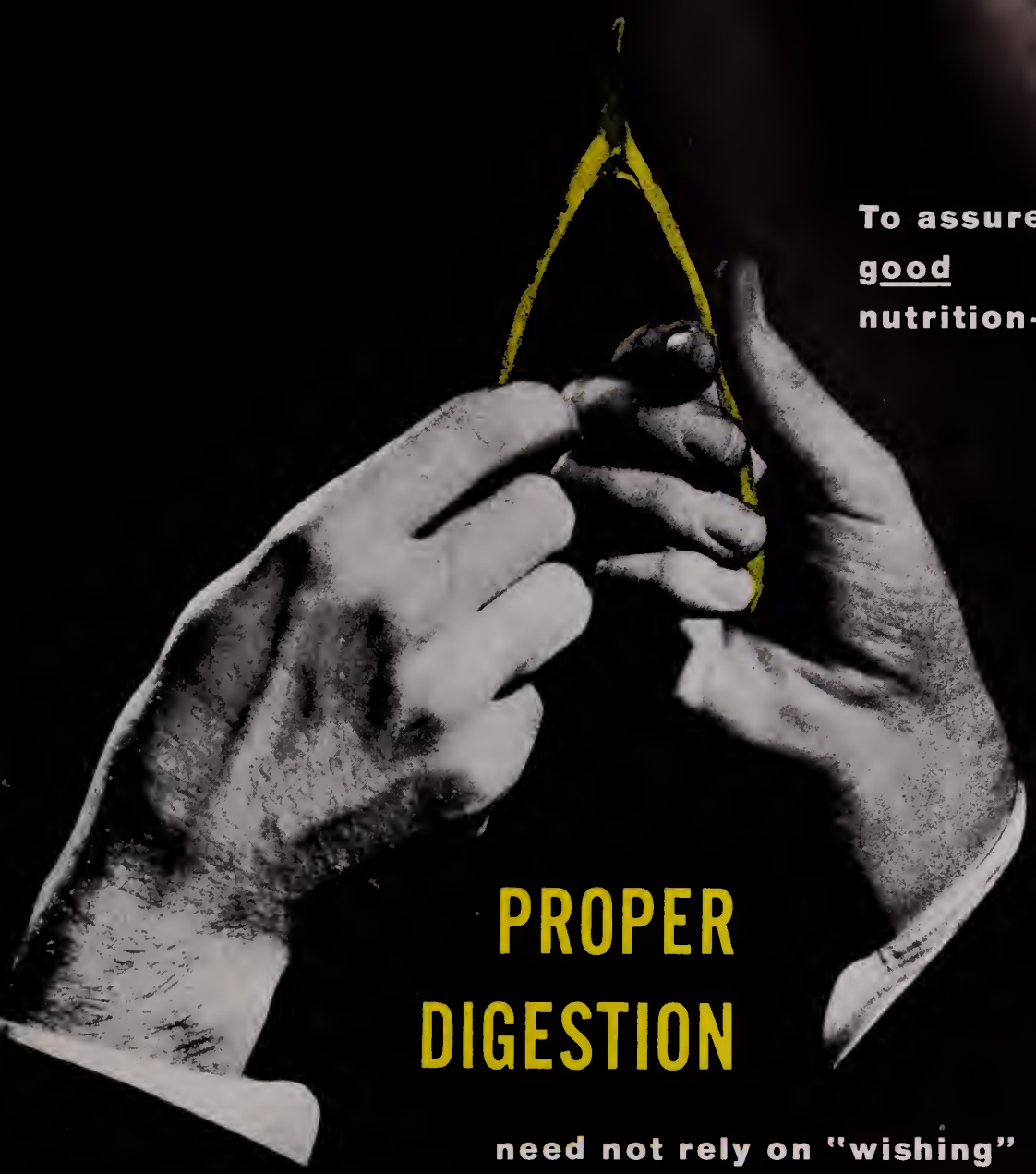
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References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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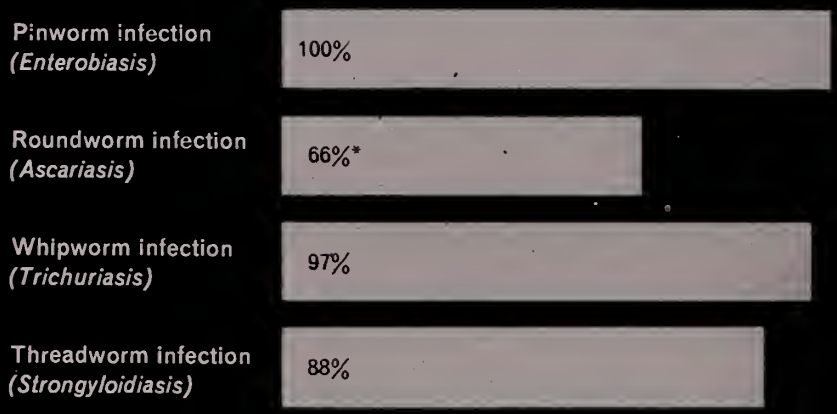
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1. Swartzwelder, J. C., et al.: J.A.M.A., 165:2063, 1957.

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Office and Bedside Evaluation Of Pulmonary Function

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GAINESVILLE

One is aware of breathing only when adequate ventilation of the lungs requires an unaccustomed effort. One is normally conscious of an increased rate and depth of breathing during vigorous exercise. Dyspnea refers to an increase in the work of breathing out of proportion to the physical exertion. The work of ventilation may be pathologically increased by several different mechanisms: (1) Increase in bronchiolar resistance as in bronchial asthma, (2) Obstruction of larger airways as with pressure on the trachea or major bronchus, (3) Stiffening of the lungs due to congestion, as in left ventricular failure or mitral stenosis, (4) Stiffening of the lungs due to pulmonary fibrosis as in silicosis, berylliosis and sarcoidosis, (5) Limitation of motion of the thoracic cage, as with pleural fibrosis and rheumatoid spondylitis, (6) Need for an increased thoracic cage motion as with paralysis of the diaphragm, and (7) Need for increased ventilation and circulation as with anemia of considerable degree. In addition, the sensation of dyspnea may arise from an increase in pulmonary ventilation out of proportion to physiologic needs, as may occur during attacks of acute anxiety. A great deal has been written about the characterization of the status of pulmonary function by detailed and complex laboratory studies, but relatively little has appeared concerning the means by which pulmonary function can be assessed at the bedside or in the office of a general physician.

There are several reasons why a physician may need to assess pulmonary function in the course of evaluating a patient. He may need to determine whether the primary complaint of dyspnea has its origin within the lungs or elsewhere. It may be desirable to determine whether there is an impairment of pulmonary function which may be contributing to the symptomatology. An assessment of pulmonary function should be a part of every complete physical evaluation of a patient who had serious pulmonary disease in the past or who is in middle or late life. It is frequently helpful to determine whether a patient has adequate pulmonary reserve to warrant referral to a thoracic surgeon for surgical management of bronchiectasis or a carcinoma. If the problem is approached rationally and with attention to the physiologic principles involved, a rather good assessment of pulmonary function can be made in the office of a general physician. Table 1 has been prepared to aid in the differentiation of the common causes of dyspnea with a minimum of equipment.

Methods for evaluation of pulmonary function in the office:

History
Physical examination
Vital capacity, observing the performance
Exercise tolerance (walking-talking tolerance)

History

In addition to the routine history and system review one should obtain the following information: (1) History of previous pulmonary disease in the past, such as pneumonia, empyema, pleural effusion, spontaneous pneumothorax, bronchial asthma, tuberculosis and chronic bronchitis. (2) History of dyspnea. If present, what is the pattern it takes? Is it accompanied by wheezing? Is it seasonal or year-around? (3) History of exposure to toxic inhalants such as silica, beryllium, as-

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bestos and silo fumes. (4) Duration and amount of smoking. Almost every patient with pulmonary emphysema is or has been a heavy smoker. (5) A careful statement of the patient's accustomed activities. Does he engage in sports, walking, climbing, and the like, or has he discontinued all physical activity which would tax his pulmonary system? Frequently a stoical patient will deny dyspnea on exertion, simply because he has not exerted himself. It may require specific questions to ascertain that he engages in almost no physical activity because his breath is too short to permit it. The best method of assessing this factor is to ask whether the patient can keep up with others of his age at various activities. (6) If dyspnea is present, is it associated with pain, present on exertion, or present on lying down, and is it ever associated with paresthesias in the fingers and carpopedal spasm? (7) The presence of a cough, whether it is productive or not. Many patients with pulmonary emphysema discount their chronic cough because they say it is just due to cigarettes. This may well be the case, without doubt, but the presence of a cough indicates bronchial irritation which plays a very great role in pulmonary emphysema. Characteristically such patients state that they have a cough on arising in the morning and that it takes 15 to 45 minutes for them to clear the mucus from the throat and chest. The mucus arises from the irritated bronchial tree, and the reason for the long period of time required to raise it is that the expulsive power of the cough diminishes with the progress of the chronic bronchitis, bronchiolitis and emphysema.

Physical Examination

In addition to the routine inspection, percussion and auscultation of the chest, particular attention should be paid to certain features. The shape and motion of the thoracic cage are noted at rest during deep inspiration. The expulsive force of expiration can be evaluated by asking the patient to blow out a match while holding it at arms length. A normal person should be able to extinguish a match under these conditions with only moderate pursing of the lips. A patient with mild impairment of expiration may be able to do so with greater pursing of the lips so as to increase

Table 1.—Differential Diagnosis of Dyspnea

	Clinical Findings	Vital Capacity		Auscultation of Lungs
Pulmonary Causes		Amount in Relation to Normal	Speed of Expiration	
Allergic asthma	Paroxysmal dyspnea	Reduced* Normal**	Slow Fast	Sibilant rales Normal
Obstructive Emphysema	Chronic exertion dyspnea; no spring-fall pattern	Reduced	Slow	Distant breath sounds; few sibilant rales
Emphysema plus bronchiolitis	Chronic exertion dyspnea with acute exacerbation; no spring-fall pattern	Greatly reduced	Very slow	Moist and sibilant rales
Pulmonary fibrosis	Shallow respiration	Reduced	Fast	Harsh breath sounds with or without rales
Rheumatoid spondylitis	Rigid spine, fixed thoracic cage	Reduced	Fast	Diminished breath sounds; limited excursion
Paralyzed diaphragm	Increased thoracic motion	Reduced	Fast	Normal
Nonpulmonary Causes				
Angina pectoris	Associated with characteristic pain and radiation	Normal or slightly reduced	Fast	Normal
Congestive heart failure (not cor pulmonale)	Edema, high venous pressure	Reduced	Fast	Moist rales, fluid
Anemia	Hemoglobin 7 Gm. per cent or less	Normal	Fast	Normal
Obesity	Very fat	Slightly reduced	Fast	Normal
Airway obstruction	Stridor	Reduced	Slow	Local stridor

*Attack
**Remission

the velocity by reducing the size of the stream. A patient with moderate emphysema will be unable to extinguish the match even with severe pursing of the lips. He may be able to blow the flame to one side but not to extinguish it. In the section on vital capacity there is a discussion of the mechanisms underlying slow expiration.

Any inequality of the two sides of the thoracic cage should be noted both in the resting position and during maximum inspiration. The chest should be auscultated during an inspiration which follows immediately upon a maximum expiration and a cough. Such maximum collapse of the lungs often brings out moist rales during the succeeding inspiration. Such rales indicate either infection with an increased mucus or congestion due to congestive heart failure.

The presence of sibilant rales (wheezes) should be noted. Sibilant rales simply indicate that there are multiple points of partial obstruction throughout the lungs, and thus they indicate expiratory obstruction. They are of no help in differentiating bronchial asthma from obstructive emphysema with bronchiolitis. This differentiation must be made from the history and the course of the disease.

Vital Capacity

In recent years the time-honored and simple test of vital capacity has fallen into an undeserved disrepute as a test of pulmonary function. This change has come about principally because of the wave of enthusiasm for the more complex and exact tests devised by the pulmonary physiologists. It is true that if the vital capacity is determined by the office assistant and only the volume or the percentage of expected normal volume is reported to the physician, it is extremely limited in its value. There are many patients with a good total vital capacity who cannot walk across the street, and many with diminished vital capacity who are asymptomatic at moderate exertion.

The most valuable tests of pulmonary function are concerned with the assessment of ventilatory function. With few exceptions there is a close correlation between ventilatory function and the more complex and exact tests of function. The two elements which one needs to assess ventilatory function of the lungs are: usable ventilatory volume (vital capacity) and the ease with which the subject can ventilate this space. If either element is limited, the subject's effective pulmonary function is impaired. One can see from figure 1 that an expiratory air flow of 1,200 cc. per second can be accomplished by the normal subject without exertion of a positive pressure within the thorax. With the exertion of expiratory effort the normal person can attain a much greater rate of expiratory air flow. The increase in expiratory flow rate is proportional to the increase in intrathoracic pressure.

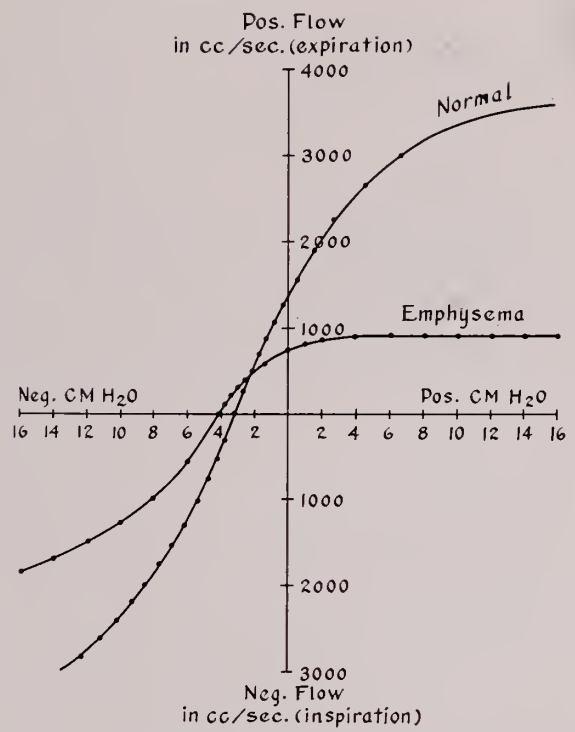


Fig. 1. — Comparison of the *velocity* of expiratory air flow in the normal subject and in a patient with severe pulmonary emphysema. Intrathoracic pressure is plotted on the horizontal axis. The normal subject can achieve greater rates of expiratory air flow with increased effort, while the patient with emphysema cannot.

The situation in the patient with partial bronchiolar obstruction to expiratory flow is strikingly different, as is shown by the curve for the emphysematous patient in figure 1. The patient with emphysema cannot accomplish a faster rate of expiratory air flow by increasing amounts of positive intrathoracic pressure. In a patient with less severe disease than the one illustrated, the pressure beyond which there is no increase in rate of expiratory flow would be somewhat higher, but a flattening of the portion of the curve to the right is characteristic of emphysema. The reason for this inability to increase the rate of expiratory flow with effort is related to the partial obstruction of the bronchioles and the fact that the bronchiolar walls are not supported. For this reason any pressure that is applied to

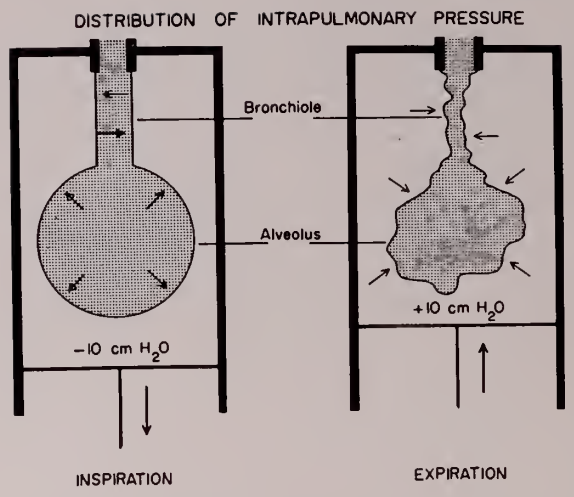


Fig. 2. — Mechanism of increasing expiratory resistance with exertion of expiratory effort in the emphysematous subject. The application of pressure to the alveoli exerts a like pressure on the collapsible bronchiole and thus further obstructs air flow.

the alveoli acts equally on the bronchioles and tends to collapse them. The degree of obstruction thus increases in proportion to the force applied and blocks an increase in expiratory rate of air flow. Figure 2 illustrates this phenomenon diagramatically.

When one observes the patient perform the vital capacity test and takes note also of the speed with which he expires the air, one can determine the ventilatory capacity of the lungs and also estimate the facility with which the patient can use the space. Only that portion which the subject can empty quickly is really useful to him under circumstances of exertion. In the presence of diffuse obstructive emphysema, bronchial asthma and airway obstruction, the speed of expiration is reduced. The total quantity of air expired may be reduced also, but it is often near normal even in the face of moderate impairment of the expiratory flow. In the presence of pulmonary fibrosis, rheumatoid spondylitis and congestive heart failure the total amount of the vital capacity is reduced but the speed of expiration is maintained. Thus a patient with a rather greatly reduced vital capacity which he can expel rapidly may have little dyspnea during moderate exercise, while a patient with a nearly normal vital capacity but slowly expelled may be dyspneic on light exercise.

There are various devices available for the determination of the vital capacity. One can use a BMR machine and obtain a written record of the effort, or one can obtain a water-filled vital capacity apparatus. All of these methods are somewhat cumbersome for the office or busy hospital ward. My practice has been to use the McKesson-Scott bellows vital capacity apparatus (fig. 3), which retails for about the same price as an aneroid sphygmomanometer. The use of disposable paper mouthpieces has also added to the convenience of the method. This instrument has no device to measure the air expelled in the first second, but I have found it satisfactory to record the total quantity expelled and then to make a note of the speed of expiration. Thus a normal healthy man might have a vital capacity of 4.5 liters rapidly expelled. I would record this as V.C. = 4.5 L (fast). A recording of 4.0 L (slow) would indicate a considerable slowing of expiration while the total capacity of the lungs showed little change. A value of 2.0 L (fast) would indicate a restriction of the expansion of the lungs or thorax but an airway free of obstruction. Such a patient might well have little dyspnea. A little experience quickly enables the physician to divide the speed of expiration into categories of fast, moderate, slow and very slow.

A refinement of this method is the use of the Gaensler-Collins timed vitalometer (fig. 4) for the measurement of the total amount of air expelled and that expelled in one, two, or three seconds. It is easy to see that it is only the air that a sub-



Fig. 3. — The McKesson-Scott vital capacity apparatus.* The metal case contains a rubber bellows.

*Available from McKesson Appliance Co., Toledo 10, Ohio.



Fig. 4. — The Gaensler-Collins timed vital capacity apparatus**

ject can expel in one second that would do him any good under conditions of exercise when the ventilation must be rapid to produce the necessary gas exchange. For this reason I record the volume expelled in one second and the total expelled. The one second volume approaches the total when no obstruction is present and constitutes a smaller fraction with increasing degrees of obstruction. A subject who has no expiratory obstruction should be able to expel at least 80 per cent of his total vital capacity in one second.

Exercise Tolerance (Walking-Talking Tolerance)

The exercise tolerance method has also been used for years as a rough test of functional capacity, but there has never been any clearcut end point. The method I use is to walk with the patient on level terrain and up at least one flight of stairs while I encourage the patient to talk. It is far more valuable to note his ability to talk continuously while walking than it is to examine him at the end of the course. Talking requires a slow, controlled expiration, regulated in accordance with the needs of the larynx and not by the rate of excretion of carbon dioxide or need for oxygen. For this reason the subject can maintain a conversation while walking only when he can comfortably excrete the carbon dioxide while breathing at a rate suitable for speech. When the excretion of carbon dioxide demands a more rapid and efficient form of respiration, talking is sacrificed. For this reason the examiner keeps the patient talking by directing the conversation to a subject in which the patient is likely to take the lead. The onset of dyspnea is indicated by the patient's talking in shorter phrases with quick expiration and inspiration between phrases and finally a reluctance to talk at all.

A stoic may deny dyspnea when he is asked about it and yet not be able to talk while walking. A psychoneurotic patient may complain bitterly of various symptoms while walking up several flights of stairs.

Finally one must evaluate the patient by considering all of the data obtained. The walking test obviously involves more factors than just pulmonary function but it is useful to see the patient perform. The portion of any dyspnea so elicited that is of pulmonary origin can usually be determined from a properly performed vital capacity test.

Summary

A rational approach to the evaluation of pulmonary function in the office or small hospital has been presented. Since there is such an excellent correlation between the complex tests of pulmonary function and ventilatory function of the lungs, one can take advantage of very simple tests of ventilation for this assessment. If this is coupled with a good history, physical examination and properly conducted exercise tolerance test, most practical problems of pulmonary function can be solved with only a minimum of inexpensive equipment.

University of Florida.

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The Surgical Treatment of Dyspnea Of Ventilatory Origin

JOHN G. CHESNEY, M.D.,
DEWITT C. DAUGHTRY, M.D.
AND
HAROLD C. SPEAR, M.D.
MIAMI

For the focus of this discussion, we have taken the symptom of dyspnea arising from depression of ventilatory function. Obviously, such disturbance may have many origins, and a study of surgical procedures applicable in its relief lies in danger of being somewhat a potpourri and may well suffer from superficiality. We have such fears for this presentation, but we are prompted to prepare it for a number of practical reasons.

Firstly, some of this material is relatively new and its presentation we believe is important. Secondly, the late stage at which the thought of application of other than the most conservative measures to some distressing ventilatory problems is considered indicates that the symptom of dyspnea should be subjected to earlier study for possible correctible mechanical factors as well as for the supplanting of some old and rather ineffective methods of therapy by more direct and effective treatment.

Pulmonary Emphysema

A distressing disease which is one of the greatest national health problems, pulmonary emphysema usually takes the form of a diffuse process throughout both lungs with the changes fairly uniform from region to region, with the exception of small bullae which may be scattered about throughout the lungs. When this bullous expression of the underlying problem becomes extremely advanced through tremendous distention, the term bullous emphysema is applied. These air sacs which may attain huge size present a particular therapeutic problem, but the diffuse process in the remainder of the lung must be kept in mind.

For this reason, the following measures are of basic importance and should be applied to all problems of this nature: (1) No smoking. No other point is so important in pure pulmonary emphysema. The patients cannot maintain adequate ventilation with a conducting bronchiolar system which is inflamed, swollen and choked with mucus and pus. Furthermore, they can ill afford to hasten the anatomic breakdown of pulmonary parenchyma through the uneven back pressures upon the pulmonary alveoli resulting from varying degrees of bronchiolar obstruction. It is truly distressing to realize how poorly stated are many physicians' instructions to stop smoking. With the reasons strongly put, success usually follows, at least in the instruction of men, and nothing can be more important for the sufferer from pulmonary emphysema. (2) Elimination of bronchitis from any other cause. (3) Breathing exercises, emphysema belts, expectorant medication and antibiotics, and intermittent positive pressure breathing using bronchodilator drugs are the purely medical technics that are invaluable.

Surgical Aids—Tracheostomy

Tracheostomy is an emergency measure of extreme value in patients with pulmonary emphysema when the balance has been upset by an accident, a bronchial infection or some other type of severe stress such as surgical operations. Tracheostomy provides a great reduction of dead space within the bronchial tree resulting in better diffusion and mixing of the respiratory gases. This device is of extreme importance when frequent aspiration of secretions is required, and it also facilitates the application of intermittent positive pressure breathing treatment through standard attachments or easily prepared substitutes.

Denervation Operations and Pleural Stripping Procedures

Unlike tracheostomy, which properly applied is well known to be life-saving, the procedures which aim at denervation of the lung and increase of its blood supply by pleural stripping have been advocated by a few surgeons. These measures, however, have attained little stature, and we think they are not worthy of clinical application.

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.

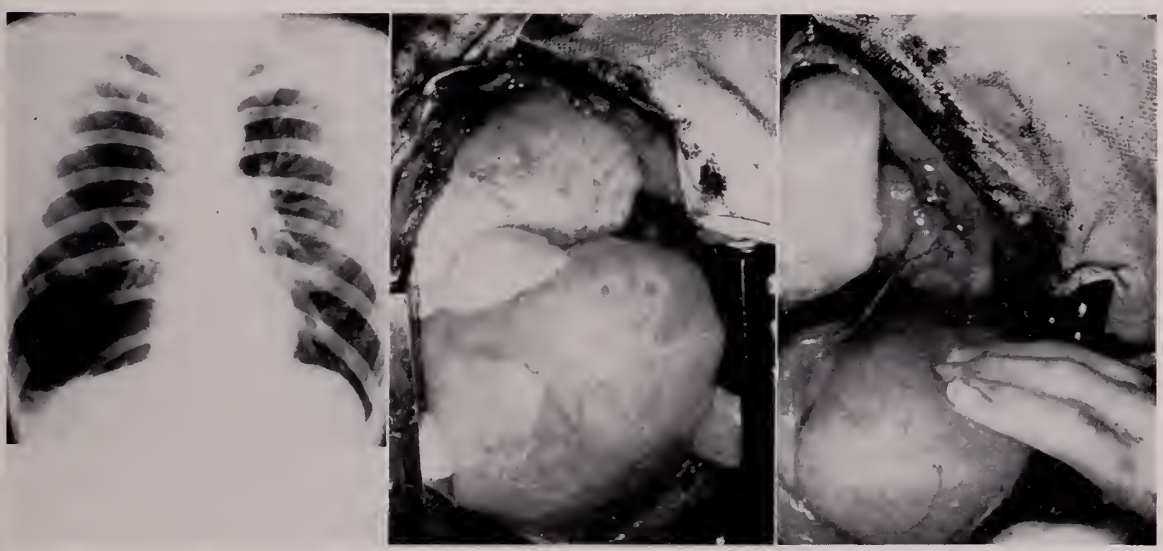
The Problem of Giant Bullae

The removal of giant bullae has as its object the release of collapsed and nonfunctioning lung tissue that has been displaced by these enormous tense sacs of air. Their removal may be obtained by simple excision of the bullae, or in the case of hopelessly involved lobes, by an appropriate lobectomy. It is of great importance that all possible functioning lung be spared, and the opportunity of improvement through the projected surgery must overbalance the pleural fibrosis, "tied up" diaphragms and similar adverse effects of thoracotomy which sometimes occur and tend to decrease ventilatory function. Selection of operative cases is therefore carefully undertaken.

The following points are of prime importance: (1) Large size of the bullae with severe compression and collapse of the adjacent lobes as seen by roentgen examination. (2) Dyspnea of a truly troublesome degree. This is almost invariably present, and episodes of unconsciousness on the slightest exertion or upon attempting to smoke are commonly reported in the history. (3) Chest pain. An inconsistent symptom, pain in the chest has been entirely absent in the history of many patients. At times, however, severe episodes of pain have occurred apparently as an expression of hyperinflation of the bullae which produced discomfort through pressure upon adjacent structures. In several cases pain in the epigastrium and anterior portions of the chest was originally interpreted as cardiac in origin, but subsequent eradication of the bullae and relief of symptoms have indicated a causal relationship. (4) Pulmonary function studies. Detailed pulmonary function evaluation is certainly an important part of the investigation of such patients and should be carried out before and after operation. In many cases presented in our series the patients were cared for prior to the availability of detailed studies of this type, but from our clinical experience we have become convinced of the value of these procedures and the improvement of ventilation following removal of such huge air sacs. It must be remembered, however, that long range results depend on the amount of good lung tissue restored to full function. It is our conviction that even an emphysematous lung performs better when released from a state of atelectatic compression (figs. 1a, b and c).

Technical Considerations

In our series of 20 cases, the procedures employed were about evenly divided between correction by lobectomy and correction through simple excision of bullae. The cardinal aim, as stated before, was elimination of the bulky air sac with preservation of any functioning lung tissue. Closure and repleuralization of raw lung surfaces



1a 1b 1c

Fig. 1a. — Posteroanterior roentgenogram demonstrating extensive localized bullous emphysema in the right lower lung field. Note hyperaeration at the right base with evidence of compression of the lung above this area.

Fig. 1b. — Same case as figure 1A., demonstrating findings at operation. An extensive bullous cyst arising in the medial segment of the middle lobe projects from the wound. The normal lateral segment of the middle lobe sits on the cyst like a cap, and the normal upper lobe is seen above it. There was compression atelectasis of part of the lower lobe.

Fig. 1c. — Showing the pedunculated nature of the bullous cyst and a portion of the compressed lower lobe behind it. The bullous cyst was easily excised with excellent re-expansion of the entire right lung.

were carried out to the fullest extent practicable. Postoperatively, through the use of multiple suction tubes and high volume, low pressure suction pumps, an expanded lung was obtained in each case.

Spontaneous Pneumothorax

A relatively common disturbance of ventilation, spontaneous pneumothorax results almost invariably from the rupture of a pleural bleb. It occurs in general in two distinct age groups.

The first group is that of the young and apparently healthy person from 20 to 30 years of age who has, as a rule, no other indication of ill health and whose roentgenogram of the chest, upon re-expansion of the lung, commonly exhibits no abnormality whatsoever. The second group is considerably older, and in these cases, the presence of diffuse and bullous emphysema is generally obvious. An asthmatic background is a contributing factor, apparently in both groups, and whereas the condition was formerly believed to be related to active pulmonary tuberculosis, it is now known that this relationship rarely exists.

The clinical characteristics are in general well known. There is commonly sharp pain in the chest followed by dyspnea and often by mild shock, a picture which is easily confused with angina, particularly in the older age group in which the inroads of emphysema have commonly reduced the intensity of breath sounds bilaterally to the point that physical evaluation may be misleading. Under these conditions, we know of several instances in which death was erroneously ascribed to acute coronary occlusion, when exodus occurred too quickly for the obtaining of roentgenograms of the chest. In the younger age group, the condition may or may not be disabling, but despite the extent of the collapse or the apparent well-being of the patient, no physician should take the responsibility of allowing such a patient to work. Properly, he belongs in the hospital under supervision. Even under these circumstances, there is a hazard in the expectant treatment of spontaneous pneumothorax, particularly when severe collapse on one side is followed by pneumothorax on the opposite side, a phenomenon which may occur in about 5 per cent of cases.

The average period of disability can be drastically reduced by introduction of a rubber thoracotomy tube into the pleural space and employment of water seal drainage. The tube will allow the expulsion of air from the pleural space, but a word of warning is in order about violent and uncontrolled re-expansion. This results in great discomfort due to rapid mediastinal shift and bronchial irritation due to mechanical displacement as well as true pulmonary edema in both the expanding and intact lung. Such discomfort can be avoided by gradually allowing the lung to expand by intermittent release of a clamp on the water seal drainage system. This procedure invariably demands a half hour of close supervision, and it is our policy to keep the tip of the drainage tube under about 2 inches of water during the first 12 hours. Thereafter, it is elevated to a point just below the surface of the water seal.

What was formerly a startling development, but now has become the expected phenomenon, is the rapidity with which the leak within the lung becomes sealed. The sealing often takes place within an hour or so, but usually requires about three days. When the absence of a further leak is proved by clamping of the system and check-up by roentgenogram, the tube is removed, and the patient is discharged. A period of morbidity of two to three weeks or more is thus reduced to an average hospitalization period of three or four days, and the threat of fatal outcome through progressive tension pneumothorax or contralateral collapse is removed.

Recurrent pneumothorax is a problem that appears in about 10 per cent of those who have previously suffered from this condition. Among those with recurrences, there is a high proportion in whom the pneumothorax tends to recur repeatedly. In 16 such cases, after repeated and prolonged difficulties and in the presence of an active leak from the pleural surface, the chest has been opened and appropriate extirpative procedures carried out. As a rule, the procedure is limited to excision of the offending bulla, though on several occasions, gross abnormalities of the lung led to lobar resection. An interesting phenomenon observed at operation serves, in our opinion, as an explanation for the prompt cessation of air leaks when complete expansion of the lung is obtained through intubation. We have repeatedly noted that bullae which stand well above the surface as perfectly transparent blister-like extrusions, can be gently brushed flat upon the surface of the lung, where probably as a result of the interior surface tension they will remain flattened despite every effort of the anesthesiologist to reinflate them. It is our supposition that in the majority of cases following closed thoracotomy, expansion of the lung presses these bullae flat

against the parietal pleura producing a temporary seal that is followed by healing.

Staphylococcus Pneumonia With Aerocele Pneumothorax and Empyema

It has been an interesting experience during the last four or five years to see the emergence of "hot" strains of medically educated drug-resistant staphylococci and the reappearance of a serious disease in the form of staphylococcus infection in the newborn. One of us (J.G.C.) remembers as an intern removing the thoracotomy tube from the first infant to survive after staphylococcus pneumonia and empyema at St. Luke's Hospital in New York City. Sulfathiazole was the drug employed in that case, and from then until the last five years, the problem of staphylococcus pneumonia was of no serious importance. The present strain, however, resistant to penicillin and numerous other valuable antibiotics, has produced an epidemic of staphylococcus pneumonia, and the interesting complications that may result from such infection belong in this discussion. The lesion in staphylococcus pneumonia consists of multicentric tiny abscesses with great necrotizing power. The process should be suspected immediately in acutely ill infants. Tremendous gaseous distention of the gastrointestinal tract is often the first sign, although careful examination may reveal pyoderma. Some form of staphylococcus infection in the mother is equally frequent.

The suspicion must not be allayed by an initial roentgenogram of the chest giving negative evidence, for the radiologic findings may not appear for another day or so, and repeating the study is mandatory. It is the policy at Variety Children's Hospital in Miami, where a considerable experience in this condition has been amassed, to supplement blood cultures with direct needling of the pneumonic lesion to attain culture and sensitivity studies as quickly as possible. If pneumothorax is produced, it is treated promptly by routine intubation.

The serious ventilatory disturbances that occur in this condition result from erosion of bronchiolar walls by staphylococcal abscesses with resulting escape of air from the bronchial system into the peribronchial tissues. These cystlike collections of peribronchial air are known as aeroceles. They may be multiple and may attain tremendous size, or, if located subpleurally, may promptly rupture into the pleural space producing pneumothorax and commonly an associated empyema.

The treatment of aeroceles is generally expectant although in isolated cases they become inflated to the point where two stage tube drainage is required to relieve compression of the remaining lung. Pneumothorax, of course, demands immediate water seal tube drainage, and to lessen the hazard of intermittent tube blockage through serum plugs we have often found it advisable to treat pneumothorax in these cases with two thoracotomy tubes. Lastly, the not infrequent empyema that occurs is treated by intubation and irrigation with small amounts of streptokinase-streptodornase solution with release of the clamp after one and one-half hours. This short period has proved to be satisfactory in that enzyme activity seems adequate and the high febrile reactions and apparent discomfort are avoided.

Chest Trauma

The frightfully mangled chest resulting from the present age of high speed air and surface travel and heavy industry is not an unusual condition, and although great strides have been made in the treatment of these injuries, much more can be done in nearly every community. Physiologists, thoracic surgeons and anesthesiologists have produced well defined and effective technics during the last 15 years which have greatly reduced the mortality when energetically applied. The objectives of initial treatment are so important that no priority should be given; all measures must be carried out simultaneously for ideal therapy. These objectives are: (1) An empty pleural space through thoracentesis in the case of blood or tube drainage in cases of associated pneumothorax. (2) A clear airway, in severe cases requiring tracheal intubation followed by tracheostomy. Blood and mucus may then be aspirated repeatedly and an insufflation machine may then be applied in cases of flail chest. (3) Shock is treated with blood, plasma, or plasma expanders. (4) The wall of the chest must be rendered an effective unit through skin or skeletal traction by pins, towel clips or whatever immediate method is available in cases of flail chest.

External measures of this nature, however, fall far short of the efficiency attained by hyperventilation and controlled positive pressure insufflation as administered by the recently developed Morch insufflator. This machine consists of a piston pump operating at a definite but controllable rate and stroke volume which produces positive pressure through a tracheostomy to expand the lungs and thoracic cage gently and then

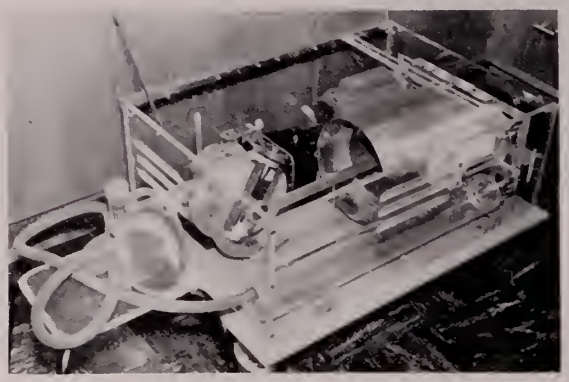


Fig. 2. — The Morch piston respirator.

allows, through an escape valve, a gentle return to essentially atmospheric pressure. Respiratory alkalosis and apnea are quickly produced, whereupon the painful muscular activity of respiration is eliminated. It is this muscular activity which produces rib overriding and, particularly in the region of the diaphragm, a severe paradox of the lower portion of the chest. Bronchial toilet is facilitated by the tracheostomy, and it is to be noted that a simple uncuffed but specially designed tracheostomy tube is used. This apparatus has been in continuous use on patients with poliomyelitis for over five months and was used over one month in one of the early patients whose chest had been pulverized as he was rolled through an 8 inch space between a locomotive and a building (fig. 2).

Funnel Chest Deformity

Funnel chest, though commonly held to be only an unsightly deformity, can, in serious cases, produce a considerable degree of functional disability directly and indirectly affecting the respiratory reserve.

This condition is characterized by general flattening of the thorax with a deep and very noticeable depression of the lower portion of the sternum. The heart is shifted to the left for lack of room anterior to the spine, and palpitation is an occasional symptom. There is usually paradoxical movement of the lower wall of the chest, which falls inward due to diaphragmatic contraction on inspiration, the same region expanding on expiration to depress directly pulmonary ventilation and impair effectiveness of cough. It is probably due to this facet of the problem that the patients seem subject to more than their share of respiratory infection and chronic bronchitis. In addition, it is commonly overlooked that the patients exhibit an immobile upper portion of the sternum which fails to lift on inspiration as should occur for proper expansion and ventilation.

Great improvement or complete correction can be obtained with a properly carried out surgical procedure. This entails total excision of the deformed portion of the costal cartilages, elevation of the sternum through an osteotomy at its upper portion and thorough lysis of its posterior attachments followed by fixation in a sharply overcorrected position that can only be maintained by an external bridge and skeletal traction applied to the sternum. The perichondrium of the resected cartilages should be left in place. Lesser procedures do not and cannot give optimum results and, while meeting these requirements demands an extensive procedure, it is a safe one under good conditions and wholly worth while.

Summary

In summary, we apologize for selecting from a host of conditions that might fit our title a series of problems that interests us and, we hope, others too, more keenly. Diaphragmatic hernias in the newborn should have been discussed in detail, but we thought that the demand for immediate correction in the neonatal period is well known. Eventration of the diaphragm, a congenital laxness of this structure in which it bulges to the apex of the chest and which is capable of amelioration by reefing of the diaphragm at open thoracotomy, is another interesting though rare condition, but time prevents paying due heed. Lastly, solid masses of all description were excluded for the same reason. The purpose of this presentation will have been achieved if the detection of dyspnea prompts further investigation in the suspicion that it may be correctible by some of the mechanical means described.

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Dissecting Aneurysm of the Aorta A Surgical Disorder

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The clinical recognition of dissecting aneurysm of the aorta now affords the physician far more than personal pride in astute diagnosis. The demonstration by DeBakey and Cooley of the feasibility of surgical treatment for this vascular catastrophy provides a potential path to recovery for the afflicted patient. Reports of only a few cases in which the patient was successfully treated for acute dissecting aneurysm of the thoracic aorta have appeared in the literature, beginning in 1955.[1] The clinical summary of a recent case is presented.

Report of Case

A 58 year old white delivery truck driver noted a transitory twinge of pain in the left posterior portion of the chest while loading clothing for delivery on March 29, 1958. One half hour later while he was seated at breakfast, sudden severe pain developed in the left side of the chest medial to the scapula. He was hopitalized at Jackson County Hospital in Marianna.

Opiates only partially relieved the pain, which did not move or radiate. It was described as a feeling of something "spreading" inside the chest. Physical examination was unrevealing except for mild hypertension. A roentgenogram of the chest (fig. 1) appeared to be normal. Electrocardiograms made on the day of admission and two days later indicated a pattern consistent with left ventricular hypertrophy with no appreciable change in the interval. Roentgenographic study of the gallbladder gave evidence of no abnormality. The pain gradually diminished in intensity, but never completely subsided despite the use of various analgesics.

The patient was discharged on the sixth hospital day to rest at home. After six days at home he again experienced severe pain in the same location. Roentgenograms of the chest (figs. 2 and 3) now demonstrated increase in width of the descending thoracic aorta, and the diagnosis of dissecting aneurysm was made by Dr. Courtland D. Whitaker.

The patient was transferred to Tallahassee Memorial Hospital on April 12. His past history was of interest in that he had been treated for hypertensive vascular disease at intervals for several years. In 1956 a diseased and nonfunctioning right kidney was removed. His blood pressure thereafter dropped to normal limits for a time, only to return gradually to the previous mild hypertensive levels for which Raudixin was administered by his physician.

On transfer, he was in mild discomfort with the pain still localized in the left posterior portion of the chest medial to the scapula. Good pulsations were felt bilaterally in the carotid, radial, and femoral vessels. The blood pressure was 170/90 in each arm. Breath sounds were diminished over the left lower portion of the chest. The pulse rate was 62 per minute, and the cardiac rhythm was regular. A soft systolic murmur was heard at the base of the heart. The heart did not appear to be enlarged. The abdomen was soft and nontender. The scar in the right flank was well healed without evidence of hernia. The other physical findings were unremarkable as were the routine blood and urine studies. A roentgenogram of the chest (fig. 4) revealed widening of the descending thoracic aorta, elevation of the diaphragm on the left side, and a small amount of fluid in the left pleural space. Fluoroscopy revealed paradoxical motion of the elevated diaphragm. Pulsations were not noted in the dilated aorta.

Exploration of the left side of the chest was undertaken on the evening of transfer. About 300 cc. of serosanguineous fluid was aspirated from the pleural space. An intense inflammatory reaction was found about the aorta, which was enlarged to twice its normal size beginning in the distal arch and extending to a point about 3 inches above the diaphragm. The aorta was mobilized, and two pairs of intercostal vessels were divided. During this portion of the procedure the systolic blood pressure remained at about 130 mm. Hg. Noncrushing clamps were used to occlude the aorta distal to the left subclavian artery and distal to the visibly dilated portion above the diaphragm. The aorta was opened transversely for about three fourths of its circumference, and clotted blood was removed from the dissected area by milking and aspiration. The layers of the aortic wall remained intact only in the posterior one fourth of the vessel's circumference. The distal dissected intima and media were sutured to the media and adventitia, obliterating the dissection and forming a single distal lumen. A wedge



Fig. 1. — Posteroanterior roentgenogram made on admission to Jackson County Hospital shortly after the onset of the illness.





Figs. 2. and 3. — Posteroanterior and left anterior oblique roentgenograms made on readmission demonstrating enlargement of the supracardiac shadow and descending aorta and elevation of the diaphragm on the left side.



Fig. 4. — Posteroanterior roentgenogram made on transfer demonstrating further enlargement of the aorta and the presence of intrapleural fluid and elevation of the diaphragm on the left side.

of the proximal dissected intima and media was excised, and the opening in the aorta was then closed with a simple continuous suture forming an end to end anastomosis (fig. 5).

The clamps were removed, allowing resumption of distal circulation after a period of complete occlusion of 26 minutes. The blood pressure, which had dropped to 130/90 with anesthetization, rose to 240/110 during the period of occlusion and dropped to 110/80 with removal of the clamps. A sheet of Dacron cloth 4 inches wide was wrapped about the area of the anastomosis and stitched in place. The dissection did not involve the aortic arch in the area of the phrenic nerve, and no cause for the paradoxical motion of the diaphragm was found other than the pleural effusion. Good pulsations were palpable in both feet immediately after operation. During the first 24 hours pulsations in the left foot disappeared, but thereafter pulsations in the lower extremities were equal and normal. Urinary output was adequate. The blood pressure gradually rose to 170/90 in each arm, where it remained at the time the patient was discharged from the hospital on April 22. The pain experienced preoperatively did not recur.

During subsequent examinations the blood pressure was found to increase gradually to 240/110 despite administration of Raudixin. Addition of Ansolysen and Diuril resulted in the return of pressures to the preoperative levels. Roentgenograms of the chest (figs. 6 and 7), made on May 5, revealed some increase in the size of the aorta as compared with the preoperative roentgenograms but no change from that noted on the first postoperative roentgenogram. It is thought that a part of this increase may be due to coagulum about the Dacron splint. Subsequent fluoroscopic examination has revealed no change in the appearance of the aorta. The diaphragm on the left side is sluggish in motion, but is no longer paradoxical.

Discussion

The mortality rate in cases of untreated dissecting aneurysm has ranged from 75 to 90 per cent.[1] Death occurs rapidly in the majority of instances due to perforation into the pericardium, mediastinum, pleura or peritoneal cavity. Experiences with subacute forms of the disease,[1] observation of the infrequent cases of so-called healed or chronic dissecting aneurysm in which the dissection re-enters the true lumen, and reports of the surgical treatment of dissecting aneurysm in the abdomen[2-4] suggested an effective surgical approach to the acute aneurysm. With means of treatment at hand, prompt clinical diagnosis has become imperative if the patient is to survive.

Although the disease is more commonly seen after the age of 50, its occurrence below the age of 40 is not unusual.[5] It occurs twice as often in men as in women. In a group of women patients under the age of 40 the dissection apparently began during pregnancy or in the early postpartum weeks in about half of the cases.

Diagnosis

The characteristic sudden onset of very severe pain in the chest or abdomen of a patient with hypertension should suggest the consideration of dissecting aneurysm in the differential diagnosis. Myocardial infarction and an intra-abdominal accident are the most common conditions to be differentiated from dissecting aneurysm. The pain is often so severe as to be unrelieved by narcotics and is sometimes described as a tearing, bursting or spreading sensation. Progressive radiation of the pain from the anterior portion of the chest to the head and neck, to the back of the chest, along the ribs, to the abdomen, and into the lower extremities, when this occurs, is almost pathognomonic and indicates the progression of the dissection.

The physical findings will depend on the location and extent of the dissection. There may

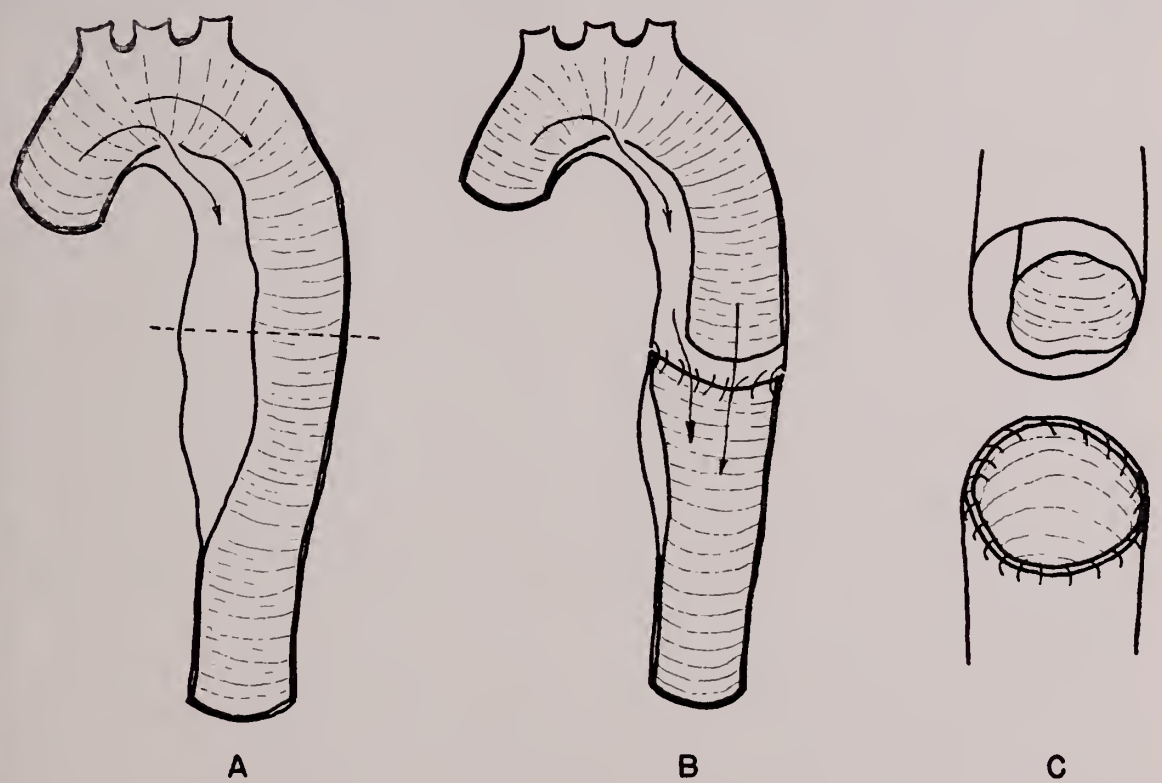


Fig. 5. — A. Diagrammatic representation of a saggital section of the aorta indicating the formation of a dissecting aneurysm along the inner curve of the arch and down the thoracic aorta. The level of the incision in the aorta is indicated approximately by the dotted line. B. Saggital section through the aorta following suture of the distal dissection to the periphery of the vessel, excision of a portion of the proximal dissected intima-media layer and closure of the aortotomy. Re-entry of blood from the dissected area proximally into the single distal lumen is indicated by arrows. C. Diagrammatic representation of the appearance of the proximal and distal aortic walls before closure of the aortotomy, shown completely divided for purposes of illustration.





Figs. 6. and 7 — Posteroanterior and left anterior oblique roentgenograms made on the twenty-third postoperative day. The aorta appears to be larger than it was preoperatively, but this increase may be due partly to the operative mobilization of the vessel and partly to the Dacron cloth splint encircling the area of anastomosis.

be no demonstrable abnormality whatever. Involvement of the branches of the aortic arch can result in neurologic manifestations such as stupor, unconsciousness, hemiplegia or paraplegia.[6] Inequality of the pulsations in the carotid or radial vessels and dissimilar blood pressure levels in the upper extremities indicate partial obstruction of these vessels by the dissection. Extension of the dissection to the iliac vessels results in absent or disparate femoral pulses, as may also occur should the dissected intima occlude the aortic lumen at a higher level. A diastolic murmur at the base of the heart, particularly as a new finding in a previously examined patient, is said to be suggestive evidence.[7] Collections of pericardial or pleural fluid or blood will produce characteristic physical changes if sufficient in amount. Abdominal tenderness and changes in the normal sounds of peristalsis may occur.

Roentgen examination of the chest is particularly helpful in supporting the diagnosis[1] and most commonly demonstrates widening of the supracardiac shadow. Oblique views are helpful in localizing the area of aortic widening. Serial roentgenograms demonstrating progressive enlargement of the aorta afford confirmatory evidence, especially when previous normal roentgenograms are available for comparison.

Electrocardiography may be of value mainly in a negative sense. A completely normal tracing is unusual in the patient with aneurysm. The pattern of left venticular strain is most commonly present.[7] When serial electrocardiograms do not reveal the characteristic patterns of myocardial infarction in a patient whose symptoms are indicative of this disease, the diagnosis of dissecting aneurysm should be considered. In contrast, the finding of electrocardiographic evidence of coronary occlusion does not exclude the possibility of dissecting aneurysm since the dissection at times involves the coronary ostia.

Other laboratory findings of some help include the demonstration of blood in the urine, anemia, and elevation of the serum nonprotein nitrogen level.[7]

As is true in many other diseases, the diagnosis is most likely to be made when the possibility of dissecting aneurysm is actively considered and a search is made for supporting evidence.

Treatment

The principle of fenestration of the internal wall of a dissecting aneurysm was first used by

Gurin, Bulmer and Derby[2] in 1935 in treating a patient whose dissection extended into an iliac artery. Johns[3] closed a ruptured dissecting aneurysm of the abdominal aorta by direct suture in 1953. Shaw[4] described the treatment of a patient in 1955 in whom fenestration of the internal wall of the dissection was performed in the abdomen. He also closed the distal plane of the dissection with sutures. Unfortunately, all three of these early efforts ended in early postoperative death of the patient.

The surgical treatment of the dissecting aneurysm of the thoracic aorta was first described by DeBakey, Cooley and Creech[1] in 1955 when the various technics used in treating six cases were outlined. In three of these cases the duration of the dissection was one month or less, and two of the patients died. Swann and Bradsher[8] and Gilman and Bailey[9] reported single cases of patients successfully treated by fenestration of the aneurysm in the chest. Warren, Beckwith and Muller[10] reported recovery of one patient in a series of five treated surgically. DeBakey, Cooley, Crawford and Morris[11] recently reported the results of the surgical treatment of 34 patients with dissecting aneurysm. They noted a 28 per cent mortality rate in this group which included chronic (more than one month duration) as well as the more acute aneurysms. Various forms of treatment including excision and prosthetic or homograft replacement as well as fenestration were used depending on the location and extent of the dissection.

The feasibility of surgical attack on this entity is thus well established. The mortality rate will probably continue to be high for the operation, but this is more a manifestation of the pathologic nature of the disorder rather than a result of the magnitude of the operation. It has been advocated that vasodepressor and vasopressor drugs be used respectively to reduce the hypertension resulting from occluding the aorta and to prevent the hypotension which follows the release of the occluding clamps.[1,10] Their use would appear to be more important when prolonged periods of occlusion are anticipated. These drugs were not used in the case reported here since the range of pressures was not thought dangerous. The use of by-pass shunts and controlled extracorporeal circulation appear to be more effective, if technically more difficult, methods of blood pressure and circulatory control.[12]

Another disturbing feature in the patient with dissecting aneurysm is a greater tendency for spinal cord damage to develop than is observed in the patient with a fusiform aneurysm. Hypothermia has been advocated to diminish this complication of treatment.[1] Efforts should be made to control hypertension postoperatively since even though the dissection has been stopped by return of the blood stream to the true lumen, the aortic wall remains weak and external rupture may occur. Replacement of the affected area by homograft or plastic prosthesis therefore seems preferable to fenestration.

The technics of these procedures have been clearly described and illustrated in the recent literature by DeBakey and Cooley. It has been pointed out, however, that "because of the pathological nature of the lesion, excisional therapy, which has proved highly effective in sacciform and fusiform aneurysms, is usually not feasible."[13] Although the technic of fenestration is not curative, in the favorable case it will satisfy the four general aims of the surgical treatment of this disorder, as outlined by Warren, Beckwith and Muller.[10] These are (1) prevention of distal extension of the aneurysm, (2) creation of a distal re-entry site for the aneurysmal sac, (3) prevention and/or relief of arterial obstruction, and (4) control of hemorrhage from the aneurysm when present.

Summary

Effective methods for the surgical treatment of dissecting aortic aneurysm are now available.

The clinical diagnosis need not be difficult provided the possibility of the disease is kept in mind and provided the commonly available diagnostic aids are used.

The relatively simple procedure of fenestration can satisfy the aims of the surgical treatment of this disorder.

One case is reported in which the diagnosis was established on the basis of meager but important evidence and in which recovery followed prompt surgical treatment.

Appreciation is expressed to Dr. Courtland D. Whitaker of Marianna for the referral of this patient and to Dr. Frederick B. Thigpen of Tallahassee, who gave important help in preoperative consultation and in the postoperative treatment.

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The Tumor Registry in a Teaching Hospital

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MIAMI

A tumor registry is a continuous audit of a group of patients from a given source who have malignant tumors. Such an audit may be carried out in a form dictated by the local need, but essentially it lists all patients with cancer and records their status at stated, usually yearly, intervals. Hospital tumor registries are now a well established fashion and are likely to remain so since they serve a definite need. This fact is attested to by the support offered them by the American College of Surgeons. The purpose of registration has been outlined by this same group.[1]

An outgrowth of individual registries has been the central registry where abstracts from two or more sources are funneled to a central agency. The general trend is in the direction of central registries, but as yet there has been no official sanction from the American College of Surgeons.[2] In this area, the American Cancer Society, with the cooperation of the Florida State Board of Health, has been interested in forming a central registry for Dade County. To this end they have arranged for hospitals to use uniform abstract forms (figs. 1 and 2), carbon copies of which are to be forwarded to the central agency. In an effort to cooperate with the central registry being developed, Jackson Memorial Hospital is using the recommended forms. These, however, are not adequate for the purposes of this particular registry. The forms are indexed, but even so become unwieldy because over 100 patients are registered each month.

It is believed that the tumor registry at a teaching institution such as Jackson Memorial Hospital should:

1. Give statistical information about the magnitude of the cancer problem in relation to other admissions.
2. Provide information about what types of tumors are commonly seen in this hospital.
3. Form a continuous audit that compares the results of treatment in this hospital from year to year and allows for comparison with published figures from other sources. Only by such an audit can results of treatment be assessed and improved upon.
4. Provide a ready source of information for medical students, house staff and attending physicians who wish to make clinical investigations.
5. Be a source of material for teams interested in clinical investigation such as the chemotherapy study now under way in the Department of Medicine.

In an effort to develop a registry which would fulfil all the purposes outlined and make information readily available, many hospitals and central registries were contacted. No single registry or combination of registries could be adapted to supply the information thought to be necessary for Jackson Memorial Hospital. With the volume and types of tumors to be registered, it was obvious that there should be a mechanical method of sorting information for ready use. Two methods presented promise. The first was the McBee Keysort cards.* This method has the virtue of sim-

From the Department of Surgery of the University of Miami School of Medicine and Jackson Memorial Hospital, Miami.

Read before the Florida Health Officers' Society, Bal Harbour, May 11, 1958.

* McBee Corp., The Date Processing Division, Port Chester, N. Y.

Name	14	15	16	17	18	19	20	REF.	JAN. FEB. MAR.	APR. MAY JUNE	JULY AUG. SEPT.	OCT. NOV. DEC.

Street Address | City | State | Reg. No.:

Name of Husband (if married woman) | Date of Admission: | Date of Discharge: | Hospital:

Age | Sex | Race | Marital Status | Private ☐ Semi-Private ☐ | Ward ☐ Clinic ☐ | Hospital No.:

DIAGNOSIS

FINAL DIAGNOSIS
(Specify primary site of cancer)

Basis of Diagnosis:
Autopsy ☐ Histology ☐ X-ray ☐ Clinical Only ☐ Other (Specify) ☐

Histological Diagnosis: (Pathology Report): Grade

Date of Diagnosis | Exfoliative Cytology

Stage of Disease: Localized ☐ Regional Involvement ☐ Remote Metastasis ☐

HISTORY

Was case positively diagnosed as cancer before this admission?
No ☐ Yes ☐ If Yes, Date:

Has patient been previously treated for this cancer? No ☐ Yes ☐
If "yes" specify date, type of treatment, and doctor or hospital
Date: Treatment:

TREATMENT

Type: Surgery ☐ Radiation ☐ None ☐ Unknown ☐
Patient Refuses Treatment ☐ Other ☐

Purpose: Curative ☐ Palliative ☐ Diagnosis Only ☐ Unknown ☐

Date and Type of Treatment:

CONDITION

Condition at Discharge: Alive ☐ Dead ☐

If Dead, Date of Death:

If Alive: No Clinical Evidence of Cancer ☐ Not free of Cancer ☐ Unknown ☐

FOLLOW-UP

Name and address of hospital or physician responsible for follow-up:

Name of person submitting this report: Date.

CANCER REGISTRY
ABSTRACT FORM

Medical Case History Bureau, 17 West 60th St., New York City Form No. ACS 2 U. S. Patent No. 1,771,740 Other Patents Pending

Fig. 1. — Form for original registration recommended by the Dade County Unit of the American Cancer Society and used at Jackson Memorial Hospital in cooperation with the local central registry.

FOLLOW-UP INFORMATION

DATE	Survival Time Months	Source of Contact	Alive	No Evidence of Cancer	Evidence of Cancer	Local Recurrence	Metastasis	Status Unknown	Dead	SUBSEQUENT TREATMENT OR REMARKS

WORK SHEET — ORIGINAL — TUMOR REGISTRY

University of Miami School of Medicine and Jackson Memorial Hospital

Name ..... Hospital #..... Age .....

Month registered (circle one)

January March May July September November
February April June August October December

Sex and race (circle one)

White male Colored male Other male Male race unknown Sex and race
White female Colored female Other female Female race unknown unknown

Marital status (circle one)

Single Divorced Widow Other
Married Separated Widower Unknown

Type of patient at time of registration
Doctors name, if private patient .....

Private inpatient
Private outpatient
Staff inpatient
Other
Staff outpatient
Staff inpatient and outpatient
Staff inpatient and tumor clinic patient
Staff outpatient and tumor clinic patient
Staff in- and out-patient and tumor clinic patient

Primary site of tumor .....

Histology of tumor (specify differentiation) .....

Metastases (circle one)

None Regional only (primary nodes) Remote only Regional and remote

Date first diagnosed as cancer .....

Method of diagnosis (circle one)

Clinical only X-ray only Histology Clinical and X-ray Other
X-ray and histology Cytology and clinical Cytology only Unknown

Initial treatment (circle one)

Surgery alone X-ray alone Hormone alone Chemotherapy alone None
Surgery and X-ray X-ray and chemotherapy Surgery and hormone Unknown
Other combination

Aim of initial therapy (circle one)

Cure Palliation Exploration only Biopsy only
Control of primary only No therapy Unknown

Condition of patient at conclusion of initial therapy (circle one)

Living without cancer Living with cancer Living status of cancer unknown
Dead of cancer Dead of other causes with cancer Dead of other causes without cancer
Dead status of cancer not known Lost to follow-up Unknown

Number of primary cancers (circle one)

1st 2nd 3rd 4th 5th 6th 7th 8th or more 9 unknown

Autopsy (circle one)

Does not apply Dead no autopsy Dead autopsy this hospital
Dead autopsy elsewhere Dead autopsy not known Unknown

Fig. 3. — Work sheet used at the time of initial registration lists the desired information.

CODE SHEET - ORIGINAL - TUMOR REGISTRY
University of Miami School of Medicine and Jackson Memorial Hospital

SUBJECT	SPACE NUMBERS	SPACES
Hospital number	1 - 6	
Age	7 - 8	
Month registered	9	
Sex and race	10	
Marital status	11	
Type of patient	12	
Primary site of tumor	13-14-15-16	
Histology of tumor	17-18-19	
Metastases	20	
Date first diagnosed as cancer	21-22-23-24	
Method of diagnosis	25	
Initial treatment	26	
Aim of initial treatment	27	
Condition of patient at conclusion of initial therapy	28	
Number of primary cancers	29	
Autopsy	30	

Fig. 4. — Code sheet from which information is transferred to the IBM card. An instruction sheet tells a clerk how to convert the information from figure 3 to this code sheet.

plicity, is inexpensive and allows sorting of limited combinations of information. A disadvantage is that the cards must be sorted manually. This method could well be adapted to smaller registries. The second was the use of a machine such as one produced by the International Business Machine Corporation.** The chief disadvantage here is the expense involved, but such a method allows for mechanical sorting and tabulation of many combinations of information. Because of the cooperation offered by the IBM Department of the University of Miami, this method of keeping a registry became available.

It was initially decided that tumors and not patients would be registered. Thus if a patient had three primary malignant tumors, all three tumors would be registered. Figure 3 summarizes the information that it is believed desirable to record at the time of registration. This forms a work sheet from which a clerk, using a simple instruction manual, may transcribe information to the International Business Machine (IBM) code sheet (fig. 4). The usual statistical information is recorded. The hospital number is the only means of identifying the case once it has been transferred to the IBM punch card. The month registered is of value chiefly for annual follow-up information. Thus it is possible to call for a list of chart numbers that were registered during a given period one year previously and these represent the cases that require annual follow-up. The primary site of the tumor is recorded according to the International Classification of Diseases,[3] and the exact histology of the tumor is listed according to The Manual of Tumor Nomenclature and Coding.[4] This arrangement is especially valuable for anyone wishing information

**International Business Machine Corp., 590 Madison Ave., New York, N. Y.

WORK SHEET — FOLLOW UP — TUMOR REGISTRY
University of Miami School of Medicine and Jackson Memorial Hospital
Annual Follow-up

NAME HOSPITAL #

First Annual Follow-up

Condition of patient (circle one)
Living without cancer — Living with cancer — Living status of cancer not known
Dead of cancer — Dead of other cause with cancer — Dead status of cancer not known
Dead of other cause without cancer — Lost to follow-up — Unknown

Treatment since initial therapy (circle one)
Surgery alone — X-ray alone — Hormone alone — Chemotherapy alone — Lost to follow-up
Surgery and x-ray — X-ray and chemotherapy — Other combination — None — Unknown

Recurrence (circle one)
Local recurrence — Local recurrence and regional metastases — Regional metastases
Remote metastases — Local recurrence, regional and remote metastases
Regional and remote metastases — Local recurrence and remote metastases
No recurrence or metastases — Unknown — Lost to follow-up

Method of diagnosing recurrence (circle one) — No recurrence — Clinical only
X-ray only — Histology — Clinical and x-ray — Lost to follow-up
X-ray and histology — Cytology and clinical — Cytology only — Unknown

Aim of therapy for this recurrence (circle one)
Cure — Palliation — Exploration only — Biopsy only — No recurrence
Control of primary only — No therapy — Unknown — Lost to follow-up

Development of another primary (circle one) — No more primary — 2nd — 3rd — 4th — 5th
6th — 7th — 8th and/or more — unknown — Lost to follow-up

Autopsy (circle one)
Does not apply (patient living) — Dead no autopsy — Dead autopsy this hospital
Dead autopsy elsewhere — Dead autopsy not known — Unknown — Lost to follow-up

Fig. 5. — Work sheet for follow-up visits. It is this form that will be sent to private physicians for completion. This will then be the source for follow-up information on these patients.

on a particular group of cases. The date of diagnosis of the cancer is noted so that time of survival can readily be determined. The remainder of the requested information is concerned with extensiveness of the tumor, the method of diagnosis, treatment and results.

Nowhere in medicine is follow-up information more important than in malignant disease since this is a major yardstick in evaluating therapy. Thus of the 80 spaces available on the IBM punch card, only 30 are used at the time of initial registration. The remaining 50 spaces are reserved for annual follow-up information. The essential follow-up information is seen in figure 5 and coded on a sheet (fig. 6). It is from this sheet that the information is transfered to the punch card, each annual follow-up requiring seven spaces. Thus there is room for seven annual follow-ups. Space 80 is reserved so that it may indicate a "trailer card" on which additional annual follow-up information may be recorded.

All staff (charity) inpatients and outpatients and private inpatients are registered. Two major sources supply the names of the patients that are to be registered. The first is the record room. Here charts on all discharged patients are coded using the Standard Nomenclature of Diseases and Operations.[5] Before filing, each chart with a diagnosis of malignant neoplasm is sent to the tumor registry clerk. The second is the Department of Pathology. Here an accession book is maintained in which the names of all patients from whom specimens are received with the histologic diagnosis are recorded. From this information charts can be obtained and patients added to the registry.

Annual follow-up information on staff patients will be obtained from their charts since they are followed in the clinic. On private patients it is believed that their physicians will be a willing source of information. A form (fig. 5) will be sent to the physician with the request that he circle the proper information in each category. This form will then be returned to the registry and the information transposed to the code sheet (fig. 6).

This method of keeping a registry will fulfil the purposes previously outlined, and as time passes a tremendous amount of readily available information will be accumulated. This will be a source for critical evaluation of the results of therapy in all types of malignant disease. It is only by comparing the results of therapy with the known natural history of the disease and with results

CODE SHEET - FOLLOW UP - TUMOR REGISTRY
University of Miami School of Medicine and Jackson Memorial Hospital

SUBJECT	SPACE NUMBERS	SPACES
Condition of patient	31	
Treatment since initial therapy	32	
Recurrence	33	
Method of diagnosing recur	34	
Aim of therapy for this recur	35	
Development of another primary	36	
Autopsy	37	
Condition of patient	38	
Treatment since first follow-up	39	
Recurrence	40	
Method of diagnosing recur	41	
Aim of therapy for this recur	42	
Development of another primary	43	
Autopsy	44	
Condition of patient	45	
Treatment since second follow-up	46	
Recurrence	47	
Method of diagnosing recur	48	
Aim of therapy for this recur	49	
Development of another primary	40	
Autopsy	51	
Condition of patient	52	
Treatment since third follow-up	53	
Recurrence	54	
Method of diagnosing recur	55	
Aim of therapy for this recur	56	
Development of another primary	57	
Autopsy	58	
Condition of patient	59	
Treatment since fourth follow-up	60	
Recurrence	61	
Method of diagnosing recur	62	
Aim of therapy for this recur	63	
Development of another primary	64	
Autopsy	65	
Condition of patient	66	
Treatment since fifth follow-up	67	
Recurrence	68	
Method of diagnosing recur	69	
Aim of therapy for this recur	70	
Development of another primary	71	
Autopsy	72	
Condition of patient	73	
Treatment since sixth follow-up	74	
Recurrence	75	
Method of diagnosing this recur	76	
Aim of therapy for this recur	77	
Development of another primary	78	
Autopsy	79	
Trailer card information	80	

Fig. 6. — Code sheet for annual follow-ups. It is from this sheet that additional punches will be made on the IBM cards.

obtained by others that the true success or failure of therapy can be measured.

Acknowledgment is gratefully made to: Mrs. Ina Hughes, who adapted the information for IBM coding; Dr. Lorenzo L. Parks, Director of the Bureau of Special Services of the Florida State Board of Health, for his support; and the IBM Division of the University of Miami.

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1000 Northwest Seventeenth Street.

ABSTRACTS

Pregnancy and Parurition in the Obese Patient. By John J. Fisher, M.D., and Ivey Frey, M.D. Obset. & Gynec. 11:92-94 (Jan) 1958.

This study of the effect of obesity on labor was carried out on 100 consecutive obese patients whose weight was 200 pounds at any time during the antepartum course. Thirteen in this group and also in the control group of 100 were primigravidas. It was concluded that obesity influences both pregnancy and parturition. The effect upon pregnancy includes a greater incidence of hypertension and toxemia but a decidedly lower incidence of anemia. Moreover, the obese patient does not gain as much weight during pregnancy, yet she loses the same amount as the nonobese patient following delivery. She should therefore show a net loss in weight over that displayed by the nonobese patient. Compared to the control group, the obese patients in this series were predisposed to a higher incidence of prolonged labor, especially that prolonged beyond 24 hours. Obesity had little influence upon complications of delivery, malpresentation, or fetal mortality. A higher incidence of persistent posterior presentation was noted in the obese patient. The results of this comparison are presented in an effort to stimulate a similar study on a larger group of patients.

Smear-Section Correlation; A Cystologic Teaching Aid. By Gladys C. Clark, B.S., M.T. (ASCP), and Alvan G. Foraker, M.D. Am. J. Clin. Path. 30:45-46 (July) 1958.

In preparing to teach exfoliative cytology to the second year class of the College of Medicine of the University of Florida as part of the pathology course, the problem of correlation of smears and sections arose. Medical students (and physicians) study stained tissue sections from their first course in histology, through pathology. Their entire microscopic orientation is based on these sections. To facilitate understanding of cells in smears, it seemed wise to attempt as close a correlation as possible. Accordingly, hematoxylin and eosin-stained sections and Papanicolaou-stained impression smears of pertinent normal and diseased tissues were mounted on the same slide. The technic is described. The authors believe that the opportunity to compare the exfoliated cells with familiar tissue sections facilitates and clarifies an introduction to the cytologic method.

Spinal Epidural Hemorrhage: Spontaneous and Recurrent. By Thomas E. Scott, Jr., M.D. South. M.J. 51:1048-1050 (Aug.) 1958.

Hemorrhage into the spinal epidural space occurs rarely as only 25 verified cases have appeared in literature. Age does not seem to be an appreciable factor, and the preponderance of males is probably due to the more frequent exposure to strain and trauma. The lesion has occurred with almost equal frequency at all levels of the spinal canal. The additional case here reported illustrates the clinical syndrome and emphasizes the fact that the lesion can be cured. In this case of recurrent spontaneous spinal epidural hemorrhage in a nine year old girl, recovery was complete following surgical evacuation of the hematoma. The syndrome associated with this lesion is discussed, and a plea is made for a high index of suspicion and early surgical therapy.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE



Ava Atque Vale

Hail and Farewell. . . . . .

The Eighty-Fifth Annual Meeting is now a part of our historical record, and this administrative year of the Florida Medical Association has come to an end.

Your officers of the past year thank you, the Membership, for the privilege of serving you—if not always wisely, at least as well as they were able. We are indebted to you for your interest, trust and active participation in the programs that have led to whatever accomplishments we as an organization may claim. You, and you alone, have made them possible. We sincerely hope that our many deficiencies and our several failures will be the subject of thoughtful and profitable analysis by the more capable team which replaces us in implementing your wishes and directives.

Last year, as your President, I was privileged to appear in many places, with many different groups; and as your representative, enjoyed the respect and confidence of leaders in all fields. This experience emphasized to me the degree to which the thinking of the American people is changing with respect to social and economic problems. I am convinced that we must become acutely aware of the fluid state of our times, and of the many dilemmas resulting from new and changing concepts.

As a profession we must participate in this evolution, and we must do so publicly, constructively, critically—but insofar as possible, without bias. We must defend our positions only after we have made certain that they are sound, tenable and in the best public interest. This is the job of the F.M.A.—to be carried out through your help and mine. Let us offer this help freely and graciously to the end that the dignity and preeminence of our profession be maintained.

Your grateful servant,

J. W. Annis

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Medical Schools and Medicine's Progress

The strides which Medicine has made toward the ultimate understanding and control of disease have been long indeed during the past two decades. The over-all death rate has declined markedly, and in cases of specific diseases the decline has been almost unbelievable. There has been alleviation from suffering in those diseases not yet brought under control, and even the newborn can look forward to almost 10 years of additional life expectancy. The strides have been great, but even greater ones must be made in the oncoming years.

It is not by accident nor by any supernatural wisdom that this progress has been made. Rather, it has come about through tireless and unselfish efforts of men in medicine who are dedicated to the belief that all questions have answers and the answers can be found if enough searching is done. These are the research men and women to be found scattered in institutions organized and operated primarily for research, in the staffs of teaching and research hospitals, in the offices of practicing physicians, and in the faculties of medical schools. They are a dedicated group and ask only that they have space, time, and funds for the conduct of their investigations.

The people of our country have become quite conscious of the contributions of the researcher, and the eagerness with which the practicing physician applies each new advance to expand his diagnostic and therapeutic armamentarium. Groups of citizens, interested in some specific condition or disease, have voluntarily organized themselves into agencies to find the dollars which will support research effort in their specific interests. Industry has recognized the dividends from investments in medical research and gives heavy dollar support. Finally, our federal government, realizing the health of its citizens is one of its most important assets, has built into its annual budgets many millions of dollars to further medical research. All in all, the combined effort totals about $300,000,000 per year, supporting thousands of projects, each contributing directly or

indirectly to a more complete understanding of the human mechanism and to a more healthy life for each individual.

It would be easy to conclude that if enough dollars were provided in the coming years, the answers to all of man's plagues could be uncovered. There is evidence that more dollars will be forthcoming, and some have estimated the annual expenditure for research by voluntary agencies, industry, foundations, and the federal government may reach the level of $1,000,000,000 by 1970. There is a serious fallacy in presuming that research can be produced by the simple expedient of providing dollars, however. Research can be productive only if there is curiosity, imagination, and dedication, and these characteristics exist, not in dollars, but in people. No one questions the need for dollar support of research, but those who provide the dollars must be aware that research will not be done except by people.

It is estimated about 20,000 professional men and women are engaged in medical research today, and if the enthusiasm and financial support continues to the level predicted for 1970, about 45,000 professional people will have to be active. If all these people were of nonmedical backgrounds, the problem of producing them might be of indirect albeit important interest to medicine. This is not the case, however. Although many of the researchers are chemists, bacteriologists, physiologists, pharmacologists, and others trained in the basic biological and physical sciences, doctors of medicine are also needed for medical research. It is because of this aspect that the medical schools must concern themselves with the production of research personnel. If all research were done outside the medical schools, we also might not have to concern ourselves so much with the problem, yet the medical schools are engaged in medical research in addition to their other duties of education and service. Of the total annual expenditures for medical research in the United States, about 20 per cent is carried in programs in the medical schools.

Over the past decade or so, medical education has been changing, both in content and presentation of the curriculum, and in the objectives of the four year program. Whereas medical schools used to be considered as having a primary objective of training for general practice, the tremendous advances in knowledge and skills have made it impossible that a four year curriculum can adequately prepare the individual for general practice. Arguments have been presented that the schools have placed too much emphasis on training for specialty practice; yet in this criticism as in that concerning general practice preparation, the four year curriculum is inadequate to prepare for specialty work. In its educational offerings, a medical school can hope only to give its students an opportunity to gain a broad foundation in the basic medical sciences and their relationships to clinical problems. During their progress through the medical curriculum, students will be influenced by many people and factors, and the ultimate application which they make of their basic backgrounds will be determined by these people and factors.

Faculties of medical schools are called upon to influence the students to choose varying careers. Of recent years, with the tremendous increase in research activity in the medical schools, they have been called upon to guide students into research interests.

In turning back to the anticipated needs if medical research is to continue its upward trend, it is evident the schools must play a greater role than they have in the past. Of the 25,000 additional research personnel expected to be needed by 1970, approximately 3,200 M.D. researchers will be needed *over and above the number of Doctors of Medicine who can be trained by the existing schools*. The answer is not an easy one, but becomes a segment of the total complex problem which faces the schools. There is evidence that more physicians for practice will be needed because of the rapidly increasing population demands. The schools themselves must try to train more Doctors of Medicine who will remain in academic medicine as teachers, and now, there is the realization that the schools will be called upon to carry more and more of the research activity in medicine with the consequent need to influence more students to turn to research interest as a career.

The task is a mighty one.



In Retrospect

The Association's extremely active retiring President, Dr. Jere W. Annis of Lakeland, found his schedule for April, the last month of his term of office, quite as demanding as it was during the other 11 months of his service. He was in Birmingham on April 9 to 11 as fraternal delegate to the annual meeting of the Medical Association of the State of Alabama; he flew from there to Tallahassee in time to present the Association's awards at the State Science Fair on April 11; and in addition to preconvention demands upon his time, he rounded out the month by addressing the Orange County Tuberculosis and Health Association in Orlando on April 30.

During his year in the Association's highest office Dr. Annis has fulfilled some 25 speaking engagements and because of other commitments has declined approximately half that number. In addition, officially representing the Association, he has attended 41 other functions without presenting an address. To meet these engagements he has traveled not only the length and breadth of the state but also of the nation for they necessitated visits to San Francisco, Washington, D. C., Chicago, Minneapolis, New Orleans and Birmingham. The miles traveled on this official business added up to 28,000.

Interestingly enough, he traveled some 10,000 miles during the year on other than the Association's business. There were trips to Washington, San Francisco, Biloxi, Miss., and elsewhere as a representative of the Florida Heart Association, Blue Shield, and the Chamber of Commerce, and for refresher courses.

Asked by The Journal to comment on the activities of his year of service, Dr. Annis replied:

"As my term as President draws to a close, my reflections are that it has been a very happy and instructive year, as far as I am concerned, and I hope a satisfactory one for the Association. It did entail more time and traveling than I had anticipated; yet I feel convinced that none of it was wasted, and that at least this much, or more, is necessary for the proper advancement of the interests of our Association. It is, of course, an exacting job; yet one which I feel must be carried out conscientiously and diligently if we are to make the advances which we contemplate. I do not believe that it imposes an impossible, or even an impracticable, strain on the individual. Financially, of course, it does impose something of a burden, but this, after all, is to be anticipated with the job.

"I have met a great many individuals, both while traveling and at the 60-odd engagements which I have kept, and amongst them made many friends which, together with the sense of service to the organization, has more than rewarded me for any possible sacrifice on my part."

Speaking to the Orange County Tuberculosis and Health Association on "The Role of the Voluntary Health Agencies in Modern Medicine and in Public Health," Dr Annis emphasized the need for voluntary health agencies and their important place in the nation's over-all health picture. He characterized their success as a fulfillment of a "basic need in a people who revere free enterprise and unlimited opportunity, as well as the rights of the human being, and who have a basic and fundamental concept that we are, at least to a degree, our brother's keeper. Here, certainly, is an opportunity for the expression of that free enterprise—limited only by the enthusiasm of the workers, and offering the satisfactory accomplishment of reaching an altruistic and satisfying goal."

May Cover



Susruta
Surgeon of Old India

Susruta, famed Hindu surgeon, is depicted in the home of a noble of ancient India, about to begin an otoplastic operation. Drugged with wine, the patient is steadied by friends as the surgeon sets about fashioning an artificial ear-lobe. He will use a section of flesh to be cut from the patient's cheek; it will be attached to the stump of the mutilated organ, treated with hemostatic powders, and bandaged.

(Courtesy of Parke, Davis & Company)

Delineating the role of physicians in relation to the voluntary health agencies, Dr. Annis said, "Their role must be in guiding the administration of the facilities and the expenditure of the time, money and talents of the organization. They must evaluate, rather than administer. Their job is that of the counselor—not the fund-raiser or the molder of public opinion. In this way they can be of real value to the millions of Americans who annually show their desire to help combat illness and disease, and who have formed the greatest agent yet known for the dissemination of medical information."

Holding the torch high as always, Dr. Annis concluded this closing address of his administration to a lay group with the salient fact his service so well exemplies that in the health field "progress is indeed our most important product."

A.M.A. Annual Meeting, June 8-12, 1959
Dr. Orr To Be Inaugurated as President

A record number of members of the Florida Medical Association should be among some 15,000 physicians who will gather in Atlantic City, N. J., next June 8-12 for the 108th Annual Meeting of the American Medical Association. This meeting is of particular interest to Florida physicians for it will mark the accession of Dr. Louis M. Orr of Orlando to the presidency of the national organization. In this well deserved honor to one of its most distinguished members the Association and all Florida take great pride.

The five day convention—the largest medical meeting in the world—is being held in Atlantic City for the sixteenth time. The first meeting was held there in 1900.

Doctors will have the opportunity to catch up on hundreds of aspects of a rapidly changing medical world. This information will be presented in the form of scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures, and industrial exhibits. New medical research findings and methods of handling daily medical problems will be reported by 500 physicians in scientific papers or participation in symposium and discussion groups. There will be over 300 scientific exhibits and a similar number of industrial exhibits on display at the famed Convention Hall. The latter group will be exhibited by pharmaceutical houses, medical equipment firms, and other manufacturers.

The House of Delegates will meet throughout the week in the Traymore Hotel, headquarters for the meeting. The 20 scientific sections of the A.M.A. and five government medical services will also be represented in the House.

First order of business for the House will be the selection of a physician to receive one of medicine's highest honors — the Distinguished Service Award. He will be elected from three persons, whose names are submitted by the Board of Trustees. Nominees are screened by the Board from names submitted by the general membership.

At the opening session Dr. Gunnar Gundersen of La Crosse, Wis., outgoing president, and his successor, Dr. Orr, will address the delegates. A president-elect to serve one year and be inaugurated as president in 1960 will be elected during the meeting.

For the fourth year, high school students who have won special A.M.A awards in the National Science Fair will show their prize-winning work at the scientific exhibit. The annual film program, another popular feature, will be highlighted by the presentation of 60 medical motion pictures.

The Woman's Auxiliary to the A.M.A. will hold its meeting Tuesday through Thursday. Representatives of the 75,000 members—all doctors' wives—will discuss their program in sessions at the Chalfonte-Haddon Hall.

Other sidelights of the meeting will be the special art exhibits including one by the American Physician's Art Association, and the forty-third annual American Medical Golfing Association tournament.

For advance hotel and meeting registration information, contact the Convention Services Department, American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

Science and the Scientist In the Satellite Age

In mid-March, during Science Week throughout the nation, Dr. Jere W. Annis, President of the Florida Medical Association, addressed the Lions Club of his home city of Lakeland on "Science and the Scientist." Timely always, with the abrupt dawning of the Satellite Age this subject has become of vital importance to every citizen of the world. Sudden, unprecedented and intense interest in scientific advance has become manifest, and the scrutiny of the entire world is now focused on scientific education. Dr. Annis' enlightening remarks are therefore stimulating.

Defining Science as "the sincere orderly investigation of everything in the world around us," Dr. Annis discussed what the creation and development of a scientist entails. He expressed amazement at the general misconception in this regard, particularly among high school students. Citing a recent survey conducted to ascertain why the number of top-flight high school graduates entering the nation's colleges and universities has steadily declined over the past five or six years, he brought out these facts:

"First of all, 14 per cent of the students interviewed felt that there was something essentially evil about Scientists, and 9 per cent believed that one could not be a Scientist and still be entirely honest. Forty-five per cent felt that their own school background was too poor to permit them to choose a career in Science, 35 per cent of them believing that it was necessary to be a genius of some sort to be a Scientist—an entirely false premise. Twenty-five per cent of those interviewed felt that Scientists as a group were more than a little odd; and a slightly greater number felt that Scientists did not have any time to enjoy life—and that they were given neither an enviable nor desirable position in our social order."

Coupled with this concept of a Scientist as a member of a somewhat mysterious shadowy calling bordering on the occult and in which there is little chance for success and acclaim was the impression of many youngsters that most of the major discoveries in Science have already been made. If the nation is to have a solid core of future Scientists, Dr. Annis declared, these erroneous concepts of intellectually well equipped high school students must be dispelled. Certainly, tremendous strides have been made along all scientific avenues, but even so, "the surface has barely been scratched, and our knowledge in all fields represents but tiny islands in the tremendous sea of our ignorance." Although the United States compares well in the scientific field with other nations, "we can keep pace only by continuing to encourage our young people to elect careers in Science—and this can be done only if such careers are made attractive from the standpoint of a reasonable financial reward and the respect of the community—for this latter is a most important factor to all of us."

To produce a real Scientist interested in discovery and research, Dr. Annis listed these requirements: "There must be a deep-seated interest and desire—a wonder and a thirst, deeply rooted in the individual himself—a hunger for knowledge, truth and the revelation of the hidden mysteries of life. This the individual must furnish; and this, I feel sure, cannot be accomplished by exposure to knowledge alone. Obviously, the candidate must have a good mind; but just as obviously he does not need to be a genius. He must be dedicated and wedded to the profession that he chooses. He must pursue it in an objective manner, using to the best of his ability his faculties of observation, judgment and deduction during every waking hour. His work must constitute the most important—indeed, almost the *only* important thing in life—for it will remain a part of him as long as he breathes. And he must pursue this restless search for more knowledge with dogged determination, undaunted by failure after failure, and brightened only by the small and infrequent flames of discovery, as long as he shall live. And he must work—work—work, unceasingly, to improve his stock-pile of knowledge, his grasp of the problem which he is attacking." These are the requirements for "the scholars—the investigators with an objective experimental approach to universal and basic problems. These are the men of Science—the Priests of Progress."

Regarding the Florida Assembly's meeting of "Atoms for Power" last fall, in which he was one of the many scientists participating, Dr. Annis commented in part: "The Assembly felt very strongly that there was need for improvement in our educational system, and that we should give priority to the cooperative effort in improving the quality of elementary and secondary education. . . . But perhaps most significantly, the Assembly felt that the education for the Nuclear Age is not simply a problem of training Scientists, technologists and technicians, but that it is even

more a problem of educating businessmen—public administrators—professional men—the whole lay public—to the needs of a new era. All of our citizens need education, in order adequately to understand and evaluate this rapidly unfolding field. All of us need to realize the importance of the facts involved in this rapid march of Science."

Rounding out his concept of Modern Science with a plea to the laity for serious and constructive thought regarding it, Dr. Annis concluded: "And let us remember, finally, that the true Scientist is engaged in the systematic exploration of the riddle of life and death—often with a view to *overcoming* death—that such discoveries as mathematical infinity—the fourth dimension—electromagnetic waves—radar, et cetera, require, when you analyze them deeply, spiritual as well as scientific equipment, and the tremendous vital energy which stems from an altruistic view of life—beginning with the love of one's neighbor and the idea of life itself as a sacrifice—and which is kept alive and active by the basic principle and idea of our Western World: the idea of freedom of personality, of thought, and of expression."

Dr. Orr Addresses Pinellas-Hillsborough Dinner Meeting

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was the guest speaker at a joint dinner meeting of the Pinellas County Medical Society and the Hillsborough County Medical Association, held in the ballroom of the Fort Harrison Hotel in Clearwater on March 2, 1959. Physicians and their wives from other neighboring counties of the West Coast area were also among some 300 who attended. Dr. Rowland E. Wood of St. Petersburg, the president of the county organization, presided, and Dr. Walter H. Winchester of Dunedin was in charge of arrangements for the dinner.

In his address, Dr. Orr discussed the positive program for older citizens now being sponsored by the American Medical Association and pointed out that the new program includes "not only the health and physical needs, but the social, economic, occupational and psychologic requirements" of this segment of the population—special considerations "that no huge federal spending will solve." He stressed over and over that the medical profession must provide leadership and imagination for a multi-phased approach to health care of the aged and must defeat the unsound Forand bill now before the Congress. This legislative health measure would put an important segment of the senior citizen population entirely under a bureaucratic system for it "is an expansion of Social Security to include hospital and perhaps medical benefits to certain Social Security beneficiaries."

This bill, Dr. Orr explained, would "add service benefits to a Social Security program that now pays cash benefits. This new principle would . . . open the door for evolution of a series of tax-paid health care for the entire nation. Indeed, it would establish the principle that provision of medical care for any segment of the population, or all of it, is a federal function." The cost, he declared, would be "exorbitant" and would result in raising the Social Security rates for all. "Such legislation," he added, "takes away individual incentives and substitutes compulsion, an idea repugnant to Americans since the time of the Revolutionary War."

"We are encouraging Blue Cross, Blue Shield and private insurance to accelerate the availability of coverage for persons over 65," he related. "A positive health program for older citizens has been launched by the A.M.A. It calls for an all-out approach to the needs of all the aged, sick or well, so that special needs will be less in the future.

"We are determined to fight proposals for compulsory health insurance in any form. American medicine holds that the principles under which voluntary prepayment plans, independent hospitals and private practice of medicine operate are too important, too valuable to throw away. We believe that every avenue should be exhausted in defense of the inherent freedoms on which they are based."

In closing, Dr. Orr expressed the belief that "we should unite as physicians, and as medical and hospital associations, in realistic, positive approaches to all phases of health care among our people, young and old."

Proceedings of Annual Meeting

The Proceedings of the Eighty-Fifth Annual Meeting of the Florida Medical Association being held May 2-6 at Bal Harbour is scheduled for publication in the July issue of The Journal.

Florida Association of Blood Banks Meets at Lido Beach May 15-17, 1959

Registration for the Thirteenth Annual Meeting of the Florida Association of Blood Banks is scheduled for 2:00 to 8:30 p.m. on Friday, May 15, at the Surf and Sand Hotel, Lido Beach, where all sessions will be held. The meeting will continue through Sunday noon. All hotel reservations should be made directly with the hotel, P. O. Box 1509, Sarasota.

Preceded by a dinner meeting of the Board of Directors, the annual business meeting will be held at 8:30 p.m. on Friday. The morning and afternoon scientific sessions on Saturday, beginning at 9 a.m. and 2 p.m., will be presided over by Dr. R. P. Tew, of Lakeland, President, and Leo L. Foster, LL.B., of Tallahassee, President-Elect. Distinguished out-of-state guests participating in the morning session will be Dr. Ralph M. Hartwell, of New Orleans, President of the American Association of Blood Banks, and Dr. Richard E. Rosenfield, Director of the Blood Bank of Mount Sinai Hospital, New York City. Dr. Hartwell's subject will be "AABB—Its Scope and Contributions." Dr. Rosenfield will lecture on "Hemolytic Disease of the Newborn Due to ABO Incompatibility" and "Identification of Immunized Donor."

Florida participants in the morning program will include Dr. James E. Kicklighter, of Sarasota, President-Elect of the Sarasota County Medical Society, who will deliver the address of welcome, Dr. John B. Ross, of Jacksonville, Medical Director of the Jacksonville Blood Bank and chairman of the Inspection and Accreditation Committee of the South East District Clearing House, whose subject is "Deficiencies Found in Blood Bank Inspections," and Dr. James J. Griffitts, of Miami, Associate Director of the John Elliott Blood Bank, and chairman of the Standards Committee of the Florida Association of Blood Banks, who will speak on "Blood Preservation and Criteria for Discarding Blood." Concluding the morning session, Mr. Foster will discuss "Liability for Injury or Death Caused by Transfusion of Blood."

Dr. Robert G. Cushman, Chief of Hematology, Riverside Hospital, Jacksonville, the first speaker on the afternoon program, will discuss "Red Cell Survival." Other speakers and their subjects include Dr. Robert E. Klein, Director of the Blood Bank of the University of Florida Teaching Hospital, Gainesville, "The Relations of Community Blood Banks With State Institutions;" Dr. Ross, "An Idea for Donor Procurement;" Col. R. E. Hunter, Clearwater, "Insurance and Finance;" Sarah D. Murphy, R.N., St. Augustine, "Report on Small Blood Banks;" Dr. Ross, "Coronary Occlusion Following Blood Donation;" and Mr. C. A. Catassi, Oakland, Calif., "Blood Bank Accounting."

The Sunday morning session will be devoted to a "Workshop for Technicians" and a "Round-table Discussion on Blood Bank Administration."

The Florida Association of Blood Banks was a pioneer in the blood bank field. The first state association to be organized, it was the inspiration of Dr. Robert B. McIver of Jacksonville and was organized even before the American Association of Blood Banks in 1947. Its excellent record of progress will be reflected in this thirteenth annual meeting, which should attract a large attendance.

Postgraduate Seminar Mount Sinai Hospital Miami Beach, May 7-9, 1959

The Mount Sinai Hospital of Greater Miami presents its Ninth Annual Postgraduate Seminar on May 7-9 at the Deauville Hotel in Miami Beach. Both the theme, "Recent Advances in Diagnosis and Therapy," and the meeting place are the same as last year. The registration fee is $20, and there is no charge for medical students, interns and residents. The Seminar is approved by the American Academy of General Practice for Category I credit.

"The Problem of Antibiotic Resistant Infections" is the subject of the first of three symposiums on the program. The other two deal with "New Concepts of Burn Therapy" and "Congestive Failure."

The distinguished lecturers and their subjects are: Dr. Ivan L. Bennett, Baxley Professor of Pathology, The Johns Hopkins University School of Medicine, "The Problems and Management of Infection," "Fevers of Unknown Origin," and "The Treatment of Pyelonephritis;" Dr. David L. Drabkin, Professor and Chairman, Department of Biochemistry, University of Pennsylvania Graduate School of Medicine, "Present Status of the Problem of the Porphyrias," "Inherent Functional Disabilities—Relative Excretory Inability for Iron, and Problems of Sideropenia and Cytosiderosis," and "Inherent Functional Disabilities—Re-

lative Excretory Inability for Uric Acid, and Problem of Gout;" Dr. John B. Hickam, Chairman, Department of Medicine, Indiana University Medical Center, "Advances in the Evaluation of Pulmonary Function," "The Circulation of the Optic Fundus in Cardiovascular Disorders, as Observed by a New Method," and "New Data in the Field of Pulmonary Failure and Cor Pulmonale;" and Dr. Joseph E. Murray, Clinical Associate in Surgery, Harvard Medical School and Massachusetts General Hospital, "Facial Fractures and Deformities," and "Organ and Tissue Homotransplantation—Physiological and Immunologic Considerations (Part I) and Surgical Considerations (Part II)."

In addition, Dr. Maurice N. Richter, Professor of Pathology and Chairman of the Department of Pathology, Postgraduate Hospital, New York City, will lecture on "Interrelationships of the Lymphomas," "Pathology of Hypersplenism," and "Indications for Splenectomy From the Standpoint of Splenic Pathology." Dr. A. Earl Walker, Professor of Neurosurgery, The Johns Hopkins University School of Medicine, will lecture on "Surgical Experiences in and About the Brain Stem," "Neurosurgical Approach to Intractable Medical Conditions," and "Surgical Consideration of Neck Pain;" and Dr. Paul Wood, Director, Institute of Cardiology and Physician to the National Heart Hospital and Brompton Hospital, London, on "The Physiological Basis of Physical Signs," "The Venous Pulse" (motion picture) and "Pulmonary Hypertension."

LETTERS TO THE EDITOR

Dear Dr. Richardson:

The attached material completes my study on "A New Treatment for Cutaneous Larva Migrans Employing Oral Promethazine," and contains information not previously available and not heretofore reported. It may be of value to those who are now trying the treatment as published in that article in the January 1959 issue of the Florida Medical Journal of the Florida Medical Association.

Treatment of Larva Migrans Addendum

Because of the possibility of the peculiar manic type reaction to promethazine (Phenergan), there may be some hesitancy in using an effective dose. It appears that this occurs more commonly in children than in adults, who are more likely to have nightmares. I have found that, with children, a small amount (6.25 to 12.5 mg.), given three times a day before meals, appears to reduce markedly the incidence of such reaction. The indicated dose (25 to 75 mg.) is given at bedtime as recommended. The same procedure may be used to "desensitize" adults; 12.5 to 25 mg. is given similarly without causing unwanted daytime drowsiness. The proper bedtime dose is given without regard to that given before; and, without regard to the minor increase in the total dosage.

In this series of 92 cases, there were no immediate or delayed toxic reactions of any kind. Many of the patients, treated for larva migrans, have been seen later for other conditions, and there have been no indications of any late effects from the drug. These patients have offered no complaints with regard to the drug itself.

The term "cutaneous" or "visceral" should be deleted in speaking of any larva migrans infestation. It is physically impossible to determine if there is — or is not—a simultaneous penetration of deeper tissues as well as of skin. In any such infestation, it must be assumed that there are indeed larvae in other tissues, even though only the cutaneous burrows are seen. The presence of an eosinophilia makes this more positive than presumptive. It is for this reason that a systemic anthelmintic is used; and, for this reason that any local treatment must be inadequate. It seems that this has not been sufficently emphasized, for several of my colleagues have questioned me about complicating an apparently successsful method which employs only simple freezing. I made before-and-after eosinophil counts in 25 cases. These showed a 10 per cent to 18 per cent eosinophilia, which returned to normal in seven to 10 days after treatment was completed. When a persistently high count was found, it was then known that the treatment had not been successful. This meant that the course had to be repeated, usually at a higher dosage level; or, that the infestation was not responding to the medication. It was found, here, that those worms not succumbing to Phenergan usually did not respond to any combination of vermicides; some infestations just did not respond to anything.

In one such case, the probable source of worms was a pet monkey. In a few cases, there may have been some indication that mice were the source. There were a few cases intimately associated with parakeets; but, I would offer no comment on a

possible connection. A number of cases appeared to have direct connection with cats or dogs. When questioning could show some reasonable relationship, the patient or family was advised to have the pet wormed. In most cases, it was not possible to discover the source of infestation. If speculation is permitted, it appears that the larvae of nematodes are not the only agents causing this condition. One may wonder if the larvae of cestodes and of trematodes are not also causative agents. Because of the behavior pattern of larva migrans, it may follow that man is neither the definitive nor the intermediate host for the adult worms.

Sincerely,
Joseph L. Greene, M.D.

OTHERS ARE SAYING

Religion and The Doctor

A very interesting innovation in the field of religious education was tried in Jacksonville in December, and it was so successful that it is worthy of being brought to the attention of the members of this society.

An invitation was extended by Bishop Hamilton West to all practicing Episcopal physicians in Florida, who belong to the American Medical Association, to attend the "Cathedral Conference on the Professions." This conference was devoted entirely to the medical profession and to the religious, moral and ethical problems encountered by those who practice the Healing Art. It was indeed gratifying to note the number of Jacksonville physicians who attended, and particularly impressive is the fact that those who attended the conference were present at all of the sessions, except for a few emergency calls which caused temporary absence.

The conference began with a dinner on a Friday evening at the Diocesan House of St. Johns Cathedral, Jacksonville, following which the first session was held in the library. Group conferences were held throughout the next day, and the participating physicians were guests for breakfast, supper, and dinner, eating together with the clergy. Sunday morning the group took Communion together; then breakfast was followed by a final group discussion, after which all attended the eleven o'clock service in a body. Between twenty and twenty-five physicians attended each session. The discussion was led by Reverend A. T. Mollegen, Professor of Systematic Divinity, Virginia Theological Seminary, Alexandria. The success of the conference can be attributed directly to the brilliant leadership and profound theological philosophy of Dr. Mollegen. His ability to take facts and thoughts and group them together into a closely-woven, concise answer to questions posed by the group was so remarkable that at no time did the discussions lag.

All who attended the conference benefitted from it, and answers to many difficult questions were worked out. The response was so encouraging that it would seem highly desirable for other religious denominations to sponsor such a conference for practicing physicians of their respective faiths. It certainly would help bring us and our practice into a closer relationship with God.

R. C. P.
Monthly Bulletin
Duval County Medical Society
February, 1959

STATE BOARD OF HEALTH

Polio Immunization and Tonsillectomy

There is considerable question in the minds of many physicians concerning the advisability of performing tonsillectomy and adenoidectomy during the polio season regardless of whether or not the child has received the triple immunization against polio.

The following abstract from a recent release from the Public Health Service is quoted in order that physicians may have the benefit of the opinion of the Service concerning this problem.

"In early January, the wire services quoted Dr. Albert Sabin, saying 'that the ban on summertime tonsil and adenoid operations in children might be lifted under some conditions. . .'

"This question was referred to Drs. Smadel and Murray of NIH and Dr. Pizzi of CDC. They believe that a risk remains in performing tonsillectomies even on persons who have received three doses of vaccine. This is due to the fact that three injections produce only about 80% effectiveness in preventing paralytic polio. Furthermore, there is evidence that polio immunization does not preclude reproduction of virus in the intestinal tract and there is evidence that the portal of entry of virus following tonsillectomy occurs from exposed nerve fibers in the pharynx where the virus is proliferating.

"If one could be assured that the immunized person had a high level of immunity to the three types of virus, there would be little risk but, of course, it is impractical to ascertain that this state exists before operation.

"An unpublished report by Neal Nathanson (cited by Dr. Pizzi) states that: 'Analysis of cases age 5-14 showed that of 22 unvaccinated bulbar cases 9 had had tonsillectomies while of 11 vaccinated bulbar cases 9 had had tonsillectomies. These data provide a slight suggestion (not statistically significant) that the tonsillectomy-related excess of bulbar paralytic cases may not be prevented by vaccination to the same extent as other types of paralytic poliomyelitis.'"

BLUE SHIELD

The Importance of A Strong National Blue Shield

DONALD STUBBS, M.D., CHAIRMAN,
BOARD OF DIRECTORS, BLUE SHIELD
MEDICAL CARE PLANS

I am reminded of the dinner held down here in the South where the Master of Ceremonies, who was a preacher, had to stand up and confess to his congregation that due to an unfortunate difficulty, unforeseen and tragic, rather than to serve peaches and cream for dessert, it was necessary to serve prunes. So if you do not like prunes, now is the time to leave, and there will be no prejudice involved.

The times are troubled for almost everyone. The argument that I might give for a strong national Blue Shield is that it would make my position more important. I could go everywhere and be welcomed with the kindness that you bestow upon me in Florida, even in Yankee territory. Now there is a satisfaction in being able to pretend honestly to rebellious feeling in foreign territory like the North. The Yankees really think they won the war and so they look down upon anyone who holds up the argument that it is not over yet. Since they think they are a majority looking upon a rather weak minority, they are always rather kind about it. Of course, those few who are still in the minority have a sympathetic attitude toward anybody who stands up and talks publicly in such terms. You cannot lose if you are a part of a real honest minority and just talk out plain anywhere you go. That is the reason Blue Shield gets along so well. You have just heard Dr. Wilhelm say this afternoon that the commercial insurance industry has spent about three or four times as much money on health care as Blue Shield has, which is true. It is a matter of record that we spend about two million dollars a working day paying doctors' claims, but that is only a relatively small part of the picture. It is an important part of it as I would like to develop.

The arguments for a strong national organization have to do with factors that have produced the change that we have all seen going on around us. There is nothing more significant about the modern age than the fact that all of the changes are continuing at a more rapid rate all of the time. The speeds of travel enable one to eat breakfast in New York and lunch in Miami, or, as soon will be the case, to eat breakfast in New York and lunch in San Francisco. They are part of the factors that have produced the shrinking world around us and the communications among people. People all over the world tend to contribute to this type of shrinkage.

So we have a situation in which all groupings that we have previously known must be broadened, expanded, and increased in their numbers if they are to have effectiveness in association with the modern problem. The trend in the United States is definitely toward increasing nationalism, and there is no denying this. At a meeting in New York, the Executive Vice-President of the Blue Cross Association emphasized that there have been a few unwritten amendments to our Constitution in this country. The first one nearly a hundred years ago was that a state or group of states may not secede from the Union. The more recent amendment is one which gives assurance that the individual citizen will be an object of

Dr. Stubbs is in private practice in Washington, D. C.

concern to the national government as far as his personal welfare is concerned. The Social Security system has been built up around this second unwritten amendment to the Constitution. If minorities and particularly if individuals are to be given protection under a democratic system, then without any question larger and larger groupings will tend to come into our way of life, and this becomes an argument for a national system of operation.

Perhaps I could add at this point a six word law to two previously enunciated 10 word laws that have created a certain amount of amusement in Blue Shield circles. The first 10 word law is, "If you play with anything long enough, it will break;" the second one, too, is a universal law, "Everything is more complicated than it seems to most people." The one I would like to enunciate and discuss briefly is, "War against entropy leads to overorganization." This requires some explanation, or you will not believe it.

Entropy is a term that the physicists and the mathematicians have used which has to do with the tendency of physical states to revert toward a system of chaos. We find that our social attitudes and efforts in the modern times tend to move into an evenly distributed chaotic existence. Bureaucracy tends to breed additional bureaucracy; all of the efforts that are produced in centralized government to deal with groups or with individuals tend to grow upon themselves, and we have the actual fact that overorganization is almost an inevitable consequence of efforts to move in these directions.

Purpose of National Blue Shield

The purpose of national Blue Shield, despite all of these eminent versions to the contrary about the tendencies that exist or overorganization for the extensive development of bureaucracy, can be stated in these terms. First of all, our efforts must be in the public interest; properly they should be so from our ethical standards. Practically they should be so because we know that success will be greatest if they are so established. There are two things that occur to me as being outstanding elements in the purpose. The first one is that in the public interest we serve our Member Plans in advancing locally controlled nonprofit physician-sponsored prepayment coverage of health insurance. Secondly, we seek to serve organized medicine in the promotion of its ideals and its practical efforts to maintain those parts of a revered profession that have served effectively for long periods of time in a voluntary self-serving system, rather than in one that is under some form of outside control.

The extent to which the voluntary system has been accepted in this country has been pointed out in the fact that 123 million out of 175 Americans today have some form of health insurance. This is not so much a proof that health insurance is now doing the job to be done as it is proof that the American people have accepted this system of coverage to such an astonishing degree. That which remains is not nearly so much to extend the numbers in this area as it is to extend the amount of coverage to each one. Blue Shield pays some of the bill for about one fourth of all the people in this country. I call your attention to the fact, however, that as we give more and more health care, we are actually multiplying our problems at the borderline between necessary and unnecessary care. We can divide the entire 175 million people into those who are sick almost to the point of death and those who are almost completely well, with the rest spread out in between. This last distribution of our people will fall into the normal distribution curve that is characteristic of all the differences that we know in living forms, including the human. If, therefore, we set all of our population into a normal distribution curve and say that we are going to give hospital care for about 10 per cent of them, at least once in the year, we draw a line then on our distribution curve that separates about 10 per cent on one side and 90 per cent on the other. The more medical care we give to more people, the larger the number will be who are borderline; they may need it and they may not need it. The decision as to which side of the line they fall on is a decision that cannot be made by the most effective brains in medicine. This is a requirement that will have to be determined by the people themselves in the last analysis, and they will buy an optimum amount of medical care.

We are dealing always here with the problem of diminishing returns for expenditure. It is perfectly possible to say that for any given case we could give more care for more people and that we might get some good from it, but when we are dealing with this statistically, we have to be concerned with what is a practical relation between the cost of care, the amount of care that is available and terms of the purveyors of the services themselves, the hospitals and doctors and people who need it. With that as a kind of general broad background, I should like to address the

problem of what we have done at the national level in Blue Shield to the present time.

Accomplishments

First of all, I believe the national organization, as has been the case in trade associations of all kinds, has furnished information in varying degrees for the Plans. This has been effective in considerable degree in many instances and has been at least some help in most instances among the 70 plus Blue Shield Plans in the country. We think that it could be very much more effective than it is and that this element of our operation is improving in two respects. I believe that under your able President, Dr. Carson, the matter of professional relations at this time is better nationally in Blue Shield than it has been at any previous time. I believe also that the technical operation at the national level can be very helpful to the Plans, particularly to those Plans which are in the stages of most rapid growth or have greatest need for it. Even here where you have been working on a new contract, it has been true that the information about contract building in other areas has been helpful.

Secondly, I believe that the national accounts operation moving toward a system of uniformity has been helpful because this is less confusing to the public which is moving around more than in previous years. The public tends to move from one Plan to another in rapid form, and similar offerings in different areas are less disturbing to them. In speaking of uniformity, I do not mean to say that national Blue Shield should aim at reduction of local option of local control. Those things, however, which have grown up naturally at the local level and are found to be similar in different parts of the country should be left in a stable form. We should cultivate our similarities and tend to play down our dissimilarities and differences at the local level because so many of our subscribers do move from one Plan to another.

We have better understanding back and forth at the A.M.A. level than ever before. In connection with the government relations, we have had a number of things that national Blue Shield has tried to stand for before the Congress in a way that was acceptable to all Plans. Among these have been the Medicare program which we helped to develop and particularly worked on in the direction of emphasizing that the program could work only by contractual agreement with physicians at the state society level, and that no Blue Shield Plan should be a prime contractor in it. It was not to be insurance at any stage, but a post payment program in which our experience and understanding of the insurance mechanism and physician relations involved might be helpful.

In connection with the problem of federal employees, there has been pressure for several years to give them health insurance of some kind, or to offer part payment towards it, as a fringe benefit incident to employment. There has been some concern in medical circles that for the government to enter this field would be improper because it would tend to use tax funds that belong to all the people in order to give benefits to a small segment of the population. It seems, however, that better understanding is coming out of the actual need for the government to act as other large employers do and to give some fringe benefits to federal employees.

In connection with the Forand type legislation, Blue Shield has been able to offer some logical support for the argument that private enterprise should be given a chance or some additional chance to show what it can do. It has been pointed out that more than 40 per cent of the over-aged people have some form of health insurance. This coverage is incomplete and overly expensive in many instances. It has been pointed out that if all the doctor bills were omitted entirely, it might not relieve this situation enough to do a great deal of good from a purely financial standpoint. But there is no question that for doctors to show honest good will in the intent to do something for a segment of our population which is important beyond its nine million numbers would attract much sympathy and attention of the rest of the population. We stand to gain a great deal of prestige before our citizen brothers in this country by offering something real to the aged who need more medical care than other members of the population. The national Blue Shield is working on a basic program to be presented at the national Board of Directors meeting in February. We hope the program can be referred for any assistance it can offer to the Plans about the country.

National Blue Shield has assisted in the arbitration of some controversies that involved doctors and their Blue Shield Plan in Connecticut. The contention that existed was rather strong between the state society and the Blue Shield Plan, and we believe it is being smoothed over in an effective way.

Future Outlook

What about the future in Blue Shield? The



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandralone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

consolidation of Blue Shield as the doctor's plan should be made in every place. The doctors understanding the special health needs of their patients have in Blue Shield a corporate structure that will enable them to have the greatest influence over the methods of management in the private insurance or free enterprise approach to the financing of health care. I think our partnership with medicine needs to be strengthened and that wherever there is a question of extending the function of this plan or of doing things that require physicians to make a greater sacrifice than in the normal operation of giving a service benefit program, this partnership needs to be at a strong working level. In other words, if the resolution passed by the House of Delegates of the A.M.A. is to be implemented, it must be implemented on the local instance of the medical profession using the Blue Shield Plan as its fiscal agent to set the pattern of a low cost program, and it must work not in the other direction. It is all right if the relations are so good that the doctors on the Blue Shield Board know that what they work out is going to be sympathetically reviewed and studied by doctors everywhere, but in general it is necessary that it be initiated by the doctors themselves as an evidence of their willingness and desire to do a good job in an area that requires special sacrifice on their part.



STATE NEWS ITEMS

Dr. H. Phillip Hampton of Tampa has been appointed a member of the Medical Advisory Board of the Sears-Roebuck Foundation.

A two week course in esophageal speech and organic voice problems has been scheduled for June 15-26 at the University of Miami School of Medicine. The course is being given this year for the fifth time and is open to specialists and resident physicians in otolaryngology, physical medicine and rehabilitation, and to speech therapists. It is under the direction of Dr. Nathaniel M. Levin, Clinical Assistant Professor of Otolaryngology. Applications are available from Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine, Coral Gables.

Drs. George S. Palmer of Tallahassee and Paul V. Reinartz of Jacksonville were principal speakers at recent meetings of the Franklin-Gulf, Walton-Okaloosa and Jackson-Calhoun County Medical Societies.

A Seminar on Care of Premature Infants will be held May 18-22 at the Premature Demonstration Center, Jackson Memorial Hospital, Miami. It is approved by the American Academy of General Practice for 35 hours credit, Category I. Information may be obtained from the Bureau of Maternal and Child Health, Florida State Board of Health, Jacksonville.

Dr. Herbert L. Bryans of Pensacola represented the Florida Medical Association at the Seventh Annual Convention of the Florida League for Nursing held April 9-10 at Pensacola. Dr. Bryans, a past president of the Association, presented greetings at the banquet held on Thursday evening.

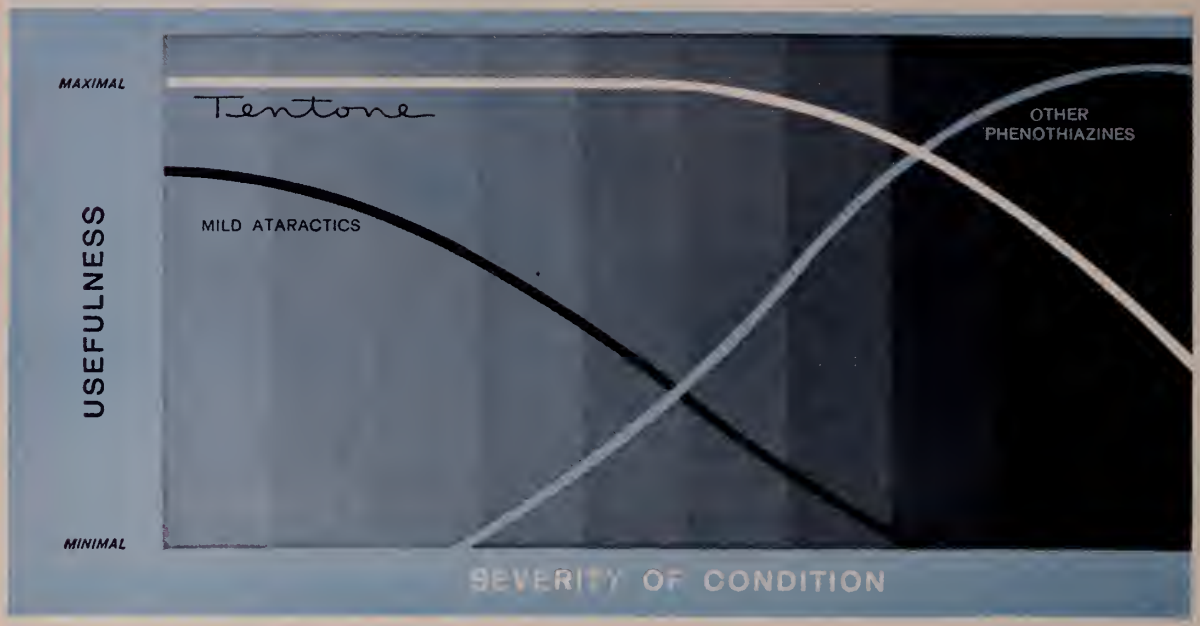
Dr. Maurice J. Jurkiewicz has been appointed Assistant Professor of Surgery at the College of Medicine, University of Florida, Gainesville. He was formerly instructor in surgery at the Washington University School of Medicine.

(Continued on page 1326)

ANNOUNCING



A HIGHLY EFFECTIVE TRANQUILIZER FOR EXTENDED OFFICE PRACTICE USE



POSITIVE CALMING ACTION ADAPTED FOR LOWER RANGE OF EMOTIONAL DISORDERS

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

EXCELLENT TOLERATION— MARKED REDUCTION IN COMPLICATIONS

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN MILD SEDATIVE EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE POTENTIATION OF ANALGESICS AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE LOWER DOSAGE RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

(Continued from page 1322)

Drs. Samuel M. Day and John A. Wilhelm of Jacksonville were principal speakers at recent meetings of the St. Johns and Alachua County Medical Societies.

A discussion of "Office Management of Hypertension" by Dr. James B. Donaldson, Department of Internal Medicine, Hahnemann Medical College, Philadelphia, began the scientific program of the annual seminar and barbecue given by the Watson Clinic at Lakeland the middle of March. Following Dr. Donaldson on the program were Dr. Ormond S. Culp, head of the Section of Urologic Surgery, Mayo Clinic, and Associate Professor of Urology, University of Minnesota School of Medicine, whose title was "Pitfalls in the Palpation of Prostates," and Dr. John H. Moyer, Chairman of the Department of Internal Medicine, Hahnemann Medical College, who discussed "Diuretics." Following an intermission, Dr. Patrick J. Kelly, Consultant in Orthopedic Surgery, Mayo Clinic and Instructor at the University of Minnesota School of Medicine, presented an address on "Management of Fractures in Children," and Dr. C. Hunter Sheldon of Los Angeles discussed "The Carotid Artery and Its Relation to Cerebral Dysfunction." The program for the evening was a symposium on automobile crash injuries. Participating in addition to Drs. Culp, Moyer, Kelly and Sheldon were Dr. Francis T. Holland of Tallahassee, Chairman of the Medical Advisory Committee, Florida State Department of Public Safety, and Mr. John O. Moore, Director of Automotive Crash Injury Research, Cornell University, New York.

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The American College of Physicians has announced three postgraduate courses to be presented in May and June: "Cardiac Arrhythmias," May 22-24, Philadelphia General Hospital, Philadelphia, Director, Dr. Samuel Bellet; "Psychiatry for the Internist," June 1-5, Psychiatric Institute, University of Maryland Hospital, Baltimore, Director, Dr. Leo H. Bartemeier, and "Special Topics in Internal Medicine," June 15-19, University of Colorado School of Medicine, Denver, Co-Directors, Dr. Gordon Meiklejohn and Dr. C. Wesley Eisele. Registration for the courses is possible by contacting the executive offices of the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

The annual meeting of the Florida Trudeau Society was held April 10-11 at Palm Beach. The scientific program included "Scalene Node Biopsy," Dr. Ivan C. Schmidt, West Palm Beach; "Special Problems in Management of Pulmonary Insufficiency," Drs. Asher Marks and Jose Bocles, Miami; "Studies on Quantitation of Unaltered Serum-INH," Dr. Alfred H. Lawton, St. Petersburg; "Phenomenon of Aspiration Pneumonia and Lung Abscess," Dr. William W. Stead, Gainesville; "Lung Biopsy," Dr. Allan L. Armstrong, Tampa; "Fate of Patients Discharged with the Open-Negative Syndrone," Dr. Raymond F. Corpe, Rome, Ga.; "Modification of the Kirshner Medium: A Rapid and Economical Culture Medium for Detection of Tubercle Bacilli," Dr. Jack Reiss, Coral Gables; "Benign Esophageal Ulcers," Dr. Franklin G. Norris, Orlando; "Unusual Case Report," Dr. Howard M. DuBose, Lakeland, and "Bronchogenic Cancer," Dr. Oscar Auerbach, East Orange, N. J. Special guest speakers included Dr. Edward T. Blomquist and Mr. Morris Barrett, Washington, D. C.

The University of Southern California School of Medicine has announced its second annual



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia and arthritic-like symptoms due t estrogen deficiency, "Premarin" take care of that, too.

"Premarin," conjugated estrogen (equine), is available as tablets an liquid, and also in combination wit meprobamate or methyltestosterone

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postgraduate refresher course in Honolulu and on board the SS Lurline July 29-August 15. Information may be obtained from Dr. Phil R. Manning, Director, Postgraduate Division, 2025 Zonal Ave., Los Angeles 33, Calif.

The Washington University School of Medicine, Division of Gerontology, St. Louis, Mo., will conduct its third annual postgraduate course in geriatric medicine May 21-23. Information may be obtained by contacting the University, 5600 Arsenal St., St. Louis 9, Mo.

The Alabama Surgical Section of the International College of Surgeons will meet May 21-22 at the Russell Erskine Hotel, Huntsville. Dr. E. V. Caldwell of Huntsville is general chairman. A feature of the program will be a tour of the Redstone Arsenal for both physicians and their wives.

Dr. Richard F. Kidder of Lake Worth has been appointed a member of the board of directors of the Florida Heart Association.

Dr. Alvan G. Foraker of Jacksonville was principal speaker at a recent meeting of the Kiwanis Club of Fernandina Beach.

Dr. Bernhard Baer of Miami Beach has been elected one of 16 regional vice presidents of the national medical fraternity, Phi Lambda Kappa.

Dr. Hilliard R. Reddick of Quincy, president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, delivered the address of welcome at the recent Cancer Conference for Nurses held at Tallahassee.

The 54th annual meeting of the American Trudeau Society is being held May 24-29 at the Palmer House in Chicago.

Dr. G. Dekle Taylor of Jacksonville spent the week of March 16 in Chicago attending a Workshop on Reconstructive Surgery of the Ear at Northwestern University.

Dr. Wilbur C. Sumner of Jacksonville presented a paper entitled "Cavernous Hemangioma of the Maxilla with Report of Cases" at the fifth annual meeting of the Society of Head and Neck Surgeons, held in Washington, D. C., March 30-31.

At the twelfth annual meeting of the James Ewing Society, held in New York City, April 2-3, Dr. Wilbur C. Sumner of Jacksonville participated in the program. He presented a paper on "Spontaneous Regression of Human Melanoma; Clinical and Experimental Study," of which he and Dr. Alvan G. Foraker of Jacksonville were co-authors.

Dr. Ralph W. Jack of Miami, President-Elect of the Florida Medical Association, was among the group of Florida physicians attending the annual meeting of the American College of Obstetricians and Gynecologists held April 6-8 at Atlantic City.

The annual meeting of the Florida Society of Medical Technologists is scheduled for May 8-10 at the Robert Meyer Hotel in Jacksonville.

(Continued on page 1332)



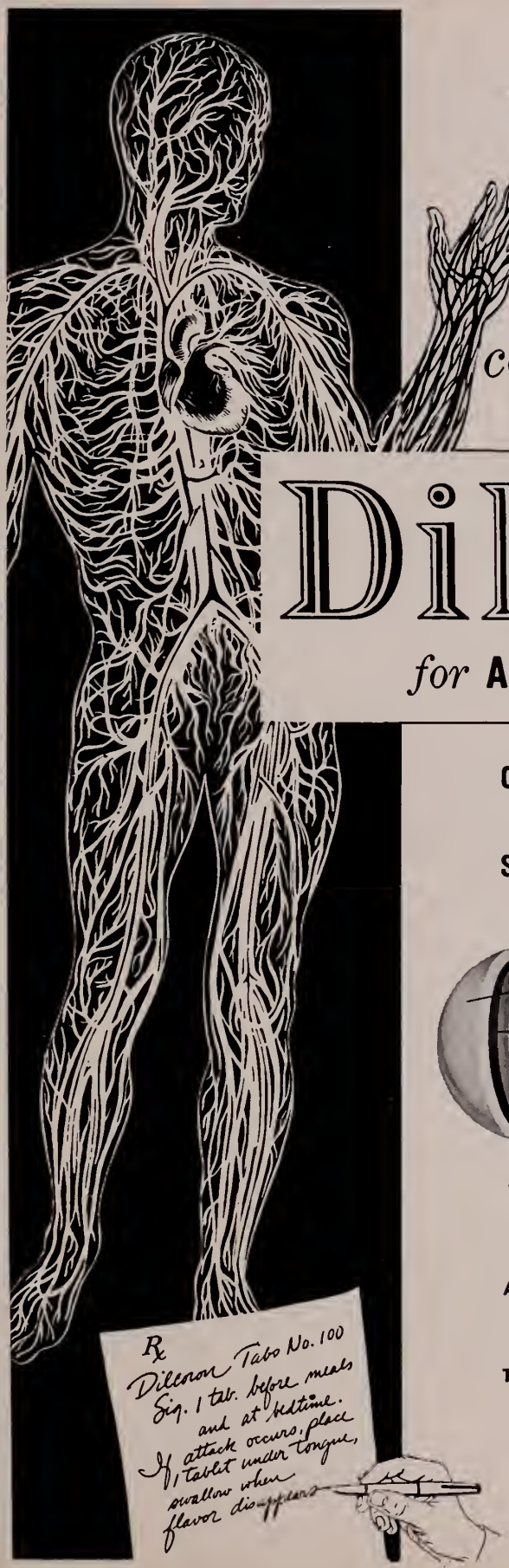
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for ANGINA PECTORIS

ORAL *(tablet swallowed whole)*
for dependable prophylaxis

SUBLINGUAL-ORAL
for immediate and sustained relief

Nitroglycerin
—0.4 mg. (1/150 grain)—acts quickly

Citrus "flavor-timer"
—signals patient when to swallow

Pentaerythritol tetranitrate
—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

Bottles of 100.

Average prophylactic dose:
1 tablet four times daily
(½ hour before meals and at bedtime).

Therapeutic dose:
1 tablet held under the tongue until citrus flavor disappears, then swallowed.

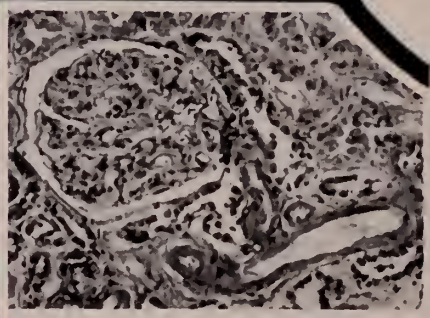
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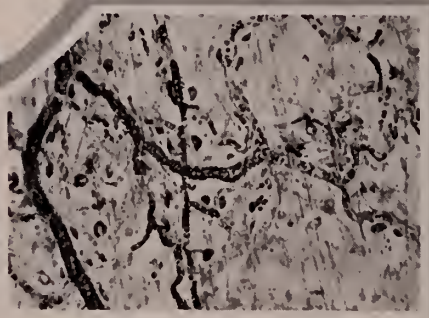
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THUS SQUIBB OFFERS YOU GREATER LATITUDE IN SOLVING THE PROBLEM OF

HYPERTENSION

WITHOUT FEAR OF SIGNIFICANT POTASSIUM DEPLETION[1-3]

Rautrax combines Raudixin with flumethiazide — *the new, safe nonmercurial diuretic* — for control of all degrees of hypertension. Clinicians report it safely and rapidly eliminates excess extracellular sodium and water without potassium depletion.[1-3] Potassium loss is less than with any other nonmercurial diuretic.[1] Moreover, the inclusion of supplemental potassium chloride in Rautrax provides added protection against potassium and chloride depletion in the long-term management of hypertension.

Through this dependable diuretic action of flumethiazide, the clinical and subclinical edema — so often associated with cardiovascular disease — is rapidly brought under control.[2-5] And once Rautrax has brought the fluid balance within normal limits, continued administration does not appreciably alter the normal serum electrolyte pattern. Flumethiazide also potentiates the antihypertensive action of Raudixin. By this unique dual action, a lower dosage of each ingredient effectively maintains safe antihypertensive therapy.

Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.

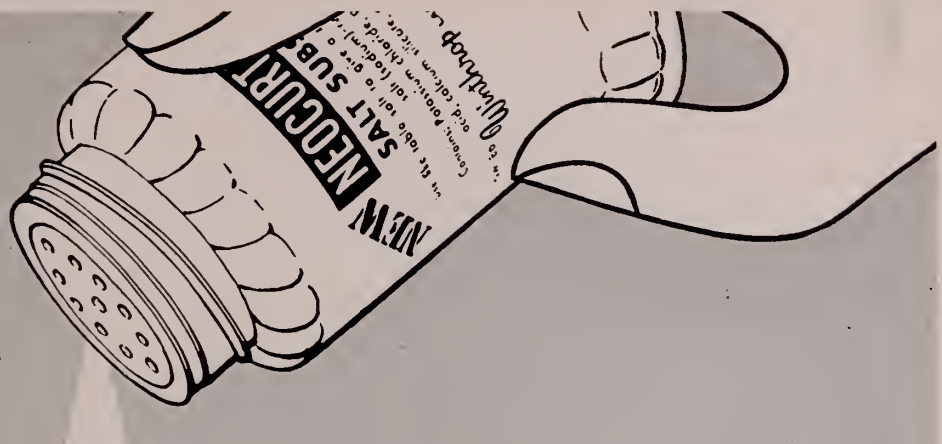
Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.

References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

LITERATURE AVAILABLE ON REQUEST.

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Valentine's MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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(Continued from page 1328)

Speakers for the scientific program beginning the second day include Dr. Morris Tager, Emory University School of Medicine; Dr. Armand J. Quick, Marquette University School of Medicine; Dr. Nathan J. Schneider, Florida State Board of Health; Dr. Emanuel Suter, College of Medicine, University of Florida; Mr. Paul C. Hudgins, Medical Research Division, Veterans Administration; and Dr. Kurt M. Dubowski, College of Medicine, University of Florida.

The following letter has been received from Mrs. Joseph E. Rose, 619 Watson Ave., Pensacola: "As you know, Dr. Rose passed away Dec. 28, 1959. I have succeeded in disposing of some of his equipment but still have an x-ray machine, diathermy machine, operating table and two small white tables. I would be glad to give these things to a doctor if he will come for them."

COMPONENT SOCIETY NOTES

Brevard

Drs. Laurent P. LaRoche and Charles E. Russell of Cocoa, and Donald M. Mosher of Melbourne presented the program for the March meeting of the Brevard County Medical Society. Each described some phase of the medical operation at the Missile Testing Center.

Collier

The Collier County Medical Society has paid 100 per cent of its state dues for 1959.

Duval

Dr. David Cayer, Professor of Internal Medicine at the Bowman-Gray School of Medicine, Winston-Salem, N. C., was principal speaker for the April meeting of the Duval County Medical Society. The title of his address was "Recent Advances in Gastroenterology."

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1959.

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1959.

Jackson-Calhoun

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Lake

Dr. William R. Daniel of Orlando was principal speaker at the March meeting of the Lake County Medical Society held at Howey-in-the-Hills. The subject of his address was the role of urology in hypertension.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. John M. Thompson of St. Petersburg was principal speaker at the April meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held at the Suwano Country Club at Quincy. Dr. Thompson discussed "Recent Advances in Neurosurgery."

Manatee

The Manatee County Medical Society has paid 100 per cent of its state dues for 1959.

Orange

Dr. James B. Donaldson of Philadelphia was the featured speaker at the March meeting of the Orange County Medical Society. Dr. Donaldson's paper was entitled "Ambulatory Treatment of Hypertension."

Pinellas

Dr. Anthony Ridolfo, a member of the research staff of Eli Lilly and Co., Indianapolis, Ind., and former Associate Professor of Pharmacy at Ohio State University, was principal speaker at the April meeting of the Pinellas County Medical Society. Dr. Ridolfo discussed "Management of Diabetes Mellitus."

Seminole

The Seminole County Medical Society has paid 100 per cent of its state dues for 1959.

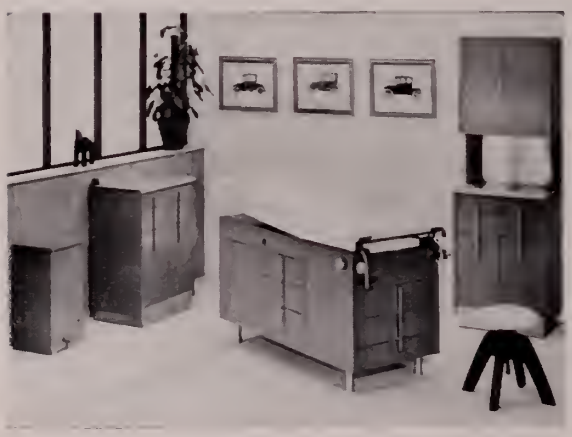
Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1959.

Volusia

Mr. Frank S. Castor, Director of the Bureau of Narcotics, Florida State Board of Health, Jacksonville, was principal speaker at the March meeting of the Volusia County Medical Society held at New Smyrna Beach. Mr. Castor discussed "Narcotic Problems in Volusia County and the Responsibility of Physicians."

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the "full-range" oral hypoglycemic agent in the management of diabetes



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DBI (N^1-β-phenethylbiguanide HCl) is an entirely new oral hypoglycemic compound, different in chemical structure, mode of action, and in spectrum of activity from the sulfonylureas. DBI is usually effective in low dosage range (50 to 150 mg. per day).

"full-range" hypoglycemic action

— DBI lowers elevated blood-sugar and eliminates glycosuria in *mild, moderate* and *severe* diabetes mellitus . . .

brittle diabetes, juvenile or adult — DBI combined with injected insulin improves regulation of the diabetes and helps prevent the wide excursions between hypoglycemic reactions and hyperglycemic ketoacidosis.

stable adult diabetes — satisfactory regulation of diabetes is often achieved with DBI alone without the necessity for insulin injections.

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smooth onset — less likelihood of severe hypoglycemic reaction — DBI has a smooth, gradual blood-sugar lowering effect, reaching a maximum in from 5 to 6 hours, and a return to pre-treatment levels usually in 10 to 12 hours.

safety — daily use of DBI in therapeutic dosage for varying periods up to $2\frac{1}{2}$ years has produced no form of clinical toxicity.

side reactions — side reactions produced by DBI are chiefly gastrointestinal and occur with increasing frequency at higher dosage levels (exceeding 150 mg. per day). Anorexia, nausea or vomiting may occur — but these symptoms abate promptly upon reduction in dose or withdrawal of DBI.

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AVAILABLE OCTOBER 1959: Board eligible Obstetrician-Gynecologist desires association anywhere in Florida. Mayo trained. Florida license. Unusually well qualified. Write 69-299, P.O. 2411, Jacksonville, Fla.

WANTED: General Practitioner to associate with G.P. in central Florida. Possibility of part time institutional work for qualified person. Write 69-303, P.O. Box 2411, Jacksonville, Fla.

PRACTICE OPPORTUNITY: for Internist, Pediatrician or General Practitioner in growing residential section of Jacksonville. Take over good starting practice, will equipped office and lease of deceased Internist for depreciated cost of equipment alone. No cash down, your terms. Write 69-306, P. O. Box 241, Jacksonville, Fla.

GENERAL PRACTITIONER: Well qualified (12 years experience) and interested all facets of general practice, desires to enter associate/group practice. Florida license, family man, draft exempt. Write 69-308, P. O. Box 2411, Jacksonville, Fla.

NEW DOCTORS OFFICE IN MELBOURNE: For rent in west section of town. Over 7000 population in this section. Excellent spot for General Practitioner and Pediatrician. Write Mr. Kelley E. George, Dairy Rd., Melbourne, Fla.

FOR SALE: Well-established ophthalmology practice in best downtown location in rapidly growing Fort Lauderdale. Nicely arranged office and favorable lease. Excellent American Optical and Bausch and Lomb equipment. Ophthalmologist can start to work immediately. Write 69-309, P.O. Box 2411, Jacksonville, Fla.

UROLOGIST: Board eligible, age 32, Florida license, one year practice experience, desires urological opportunity, Association or group preferred. Write 69-310, P.O. Box 2411, Jacksonvill, Fla.

WANTED: General Practitioner including OB and surgery. Excellent hospital facilities. Good opportunity for right man. Good income. South Florida, East Coast. Write 69-311, P.O. Box 2411, Jacksonville, Fla.

WANTED: Six months General Practice locum tenens or group association July 1, 1959-January 1, 1960 by young, Florida-licensed doctor with full surgical training (prior to additional residency). Write 69-312, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: H. G. Fischer "Spacesaver" 50 ma Radiographic-Fluoroscopic Unit and Examining Table plus accessories. 1958 model used only 6 months. To sell at sacrifice. Write 69-314, P.O. 2411, Jacksonville, Fla.

WANTED: Electroencephalographer to establish department in 600 bed general hospital. Florida license required. Part time percentage basis. Extramural private practice likely necessary. Contact Hospital Director, Tampa General Hospital, Tampa 6, Fla. (Telephone 8-0711).

WANTED: Mature General Practitioner and Surgeon looking for office space with another doctor. Florida licensed and located. Will exchange references. Available immediately. Write 69-313, P.O. Box 2411, Jacksonville, Fla.

WANTED: Location by otolaryngologist. Board Certified. Have Florida License. Write 69-302, P. O. Box 241, Jacksonville, Fla.

PEDIATRICIAN WANTED: Board qualified or certified to practice in desirable community where established pediatricians are forced to turn away patients daily. Write 69-315, P.O. Box 2411, Jacksonville, Fla.

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In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

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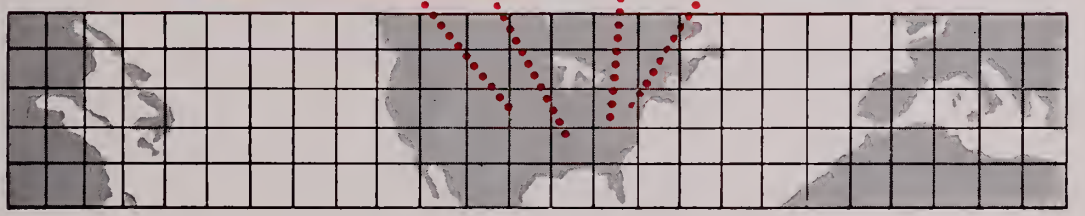
(brand of hydroxyzine)

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"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

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"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

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ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
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For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Adler, Sidney, Miami
Artzibushev, Constantin, Tampa
Balli, Carl E., Miami
Bates, James S. Jr., Hollywood
Bradley, Matthew H., Miami
Carratt, James A., Daytona Beach
Carroll, Maxwell G., Crestview
Dean, Henry L., Miami
DeLand, Frank H., Lakeland
Ehrenreich, Jacob, Coral Gables
Ellis, Ernest B., Coral Gables
Ewing, Richard M., Fort Lauderdale
Fuzy, Paul J. Jr., Fort Lauderdale
Gerspacher, Thomas S., South Miami
Goldstein, Norman, Sarasota
Goodrich, Howard B., Winter Park
Gordon, John E., Pompano Beach
Halpern, Arthur E., Miami
Harding, Paul C., Orlando
Jaffe, Robert J., Miami Beach
Jeffrey, Stewart L., Miami
Klein, Warren E., Fort Lauderdale
Litwak, Robert S., Miami
Lozman, Harvey, Miami
McEuen, Harry B. Jr., Jacksonville
McEuen, Marianne B., Jacksonville
Overby, Harry T., Miami
Parker, James W., Avon Park
Petkas, Nicholas S., West Palm Beach
Ross, Carl, Jacksonville
Rudolph, Burton M., Miami Shores
Saunders, Earl N., Marianna
Shaver, William A., Miami
Sherrill, Robert G. Jr., Tampa
Stephan, Ralph M., Tampa
Stocking, Bruce W., Fort Lauderdale
Swartzendruber, Frederick J., Sarasota
Thames, Rufus, Milton
Vaujin, Octavio A., Hollywood
Weisbart, Myron H., Fort Lauderdale
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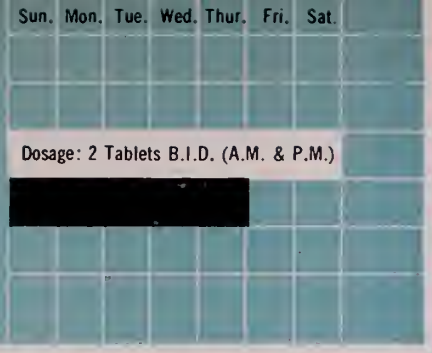
of Jacksonville

Jacksonville
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Telephone EL 4-6661

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1511 Sligh Blvd.
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in premenstrual tension only neo Bromth treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

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Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 279 applicants who took the examination of the Board, held November 24 and 25, 1958, in Miami Beach, 238 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 238 applicants follow:

Adeeb, Allan Jerome, Jacksonville (U. Tenn. 1957)
Aghajanian, George Kevork, Miami (Yale U. 1958)
Alfonso, Silvie Louis, Miami (U. Penn. 1957)
Anderson, Robert Hoyt Jr., Jacksonville (Med. Col. Georgia 1956)
Anthony, Bascom Frank, Macon, Ga. (Emory U. 1956)
Anzalone, Joseph Thomas, Pittsburgh (U. Pittsburgh 1957)
Aron, Jack Donald, Chicago (U. Illinois 1956)
Arroyo, Pedro Jr., Bronx, N. Y. (Columbia U. 1952)
Beacher, Milton Daniel, Brooklyn (G. Washington U. 1936)
Beber, Charles Robert, Miami (U. Nebraska 1954)
Beck, Richard Lowe, Pittsburgh (Hahnemann 1957)
Beck, Robert Anthony, Kalispell, Mont. (Indiana U. 1945)
Becker, Matthew Kurt, Miami (Washington U. 1958)
Beckman, Franklin, Miami (Boston U. 1956)
Bell, Robert Edgar Jr., Jacksonville (Bowman Gray 1958)
Belott, August Vincent, Tampa (U. Buffalo 1931)
Berg, Eliot Hubert, Brooklyn (State U. New York 1953)
Bradley, Donald John, Buffalo (New York Med. 1956)
Braman, Robert Tilden, Chicago (U. Illinois 1949)
Breakstone, Irving Lawrence, Miami Beach (Chicago Med. Sch. 1938)
Brock, Charles Lee, Philadelphia (Duke U. 1954)
Bronnenberg, Neel H., Tampa (Indiana U. 1953)
Brown, Marcus Frederick, Starke (U. Miami 1958)
Bullington, Donald Clifton, Hollywood (U. Michigan 1953)
Bullington, Walter Graham, Pensacola (Virginia Med. Col. 1957)
Bunim, Louis Albert, Brooklyn (New York U. 1923)
Burke, Herbert Anderson Jr., Pensacola (Vanderbilt U. 1955)
Butler, William Joseph, St. Joseph, Mich. (U. Illinois 1941)
Campbell, Thomas Allen, Bay Pines (Loyola U. 1951)
Campbell, Thomas Edward, Tampa (U. Louisville 1958)
Carroll, John Joseph, Niagara Falls (U. Western Ontario 1938)
Cashman, Edward Leonard Jr., Gainesville (Tufts 1949)
Cebula, Jerome Matthew, North Bergen, N. J. (Long Island Col. Med. 1940)
Chobot, Edwin Frank Jr., Lookout Mountain, Tenn. (U. Tenn. 1953)
Clancy, Daniel Henry Jr., Boston (Tufts 1943)
Clegg, Frederick Lee, St. Petersburg (Ohio St. U. 1958)
Cobos, Limbano, Daytona Beach (U. Havana 1950)
Cohen, Harold A., Miami (Indiana U. 1958)
Cohen, Irving Victor, Key West (Alabama Med. Col. 1957)
Cohen, Jerome Irwin, St. Petersburg (Jefferson 1958)
Cole, George William, Miami (U. Miami 1958)
Coleman, John Frederick, Toledo, Ohio (Ohio St. U. 1958)
Colton, Edmund John, Colorado Springs, Colo. (Northwestern U. 1946)
Conway, John Herbert, Larchmont, N. Y. (U. Cinn. 1928)
Cooke, James Kenneth Jr., Cecil Field (U. Tenn. 1955)
Cooke, Reginald Henry, Jacksonville (St. U. Syracuse 1955)

(Continued on page 1348)

The patient with gastrointestinal dysfunction often finds the printed page blurred like this, because of the side effects of some antispasmodics. He may be so disturbed that he abandons treatment. But you can provide safe, effective relief of pain and spasm without risk of blurred vision with...

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direct antispasmodic action plus control of anxiety and tension without blurred vision, dry mouth or loginess associated with barbiturates, belladonna and bromides.

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each scored tablet contains: meprobamate 400 mg., tridihexethyl chloride 25 mg., (formerly supplied as the iodide).

DOSAGE:
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1. Neutralizes acid faster (quicker relief)

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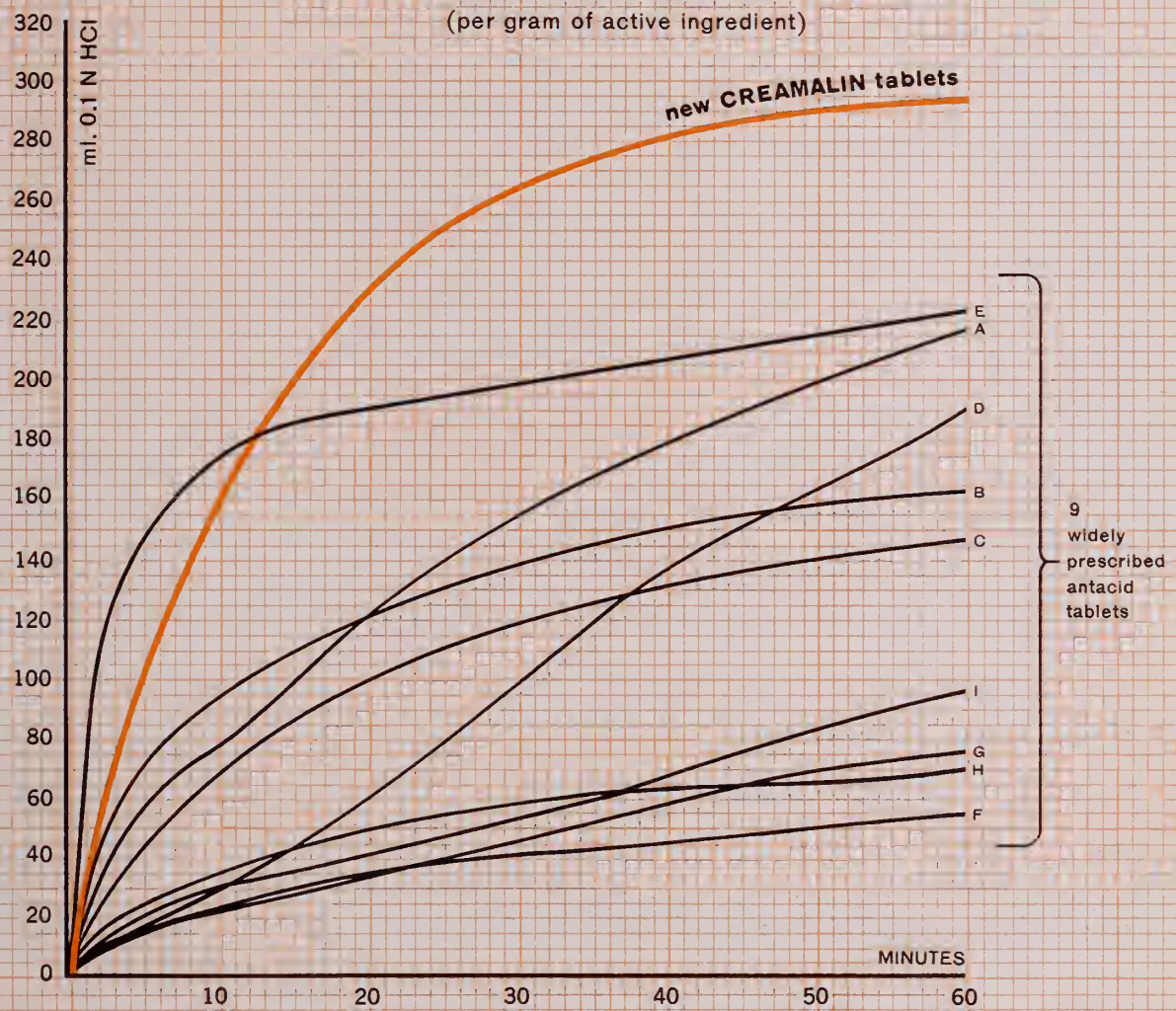
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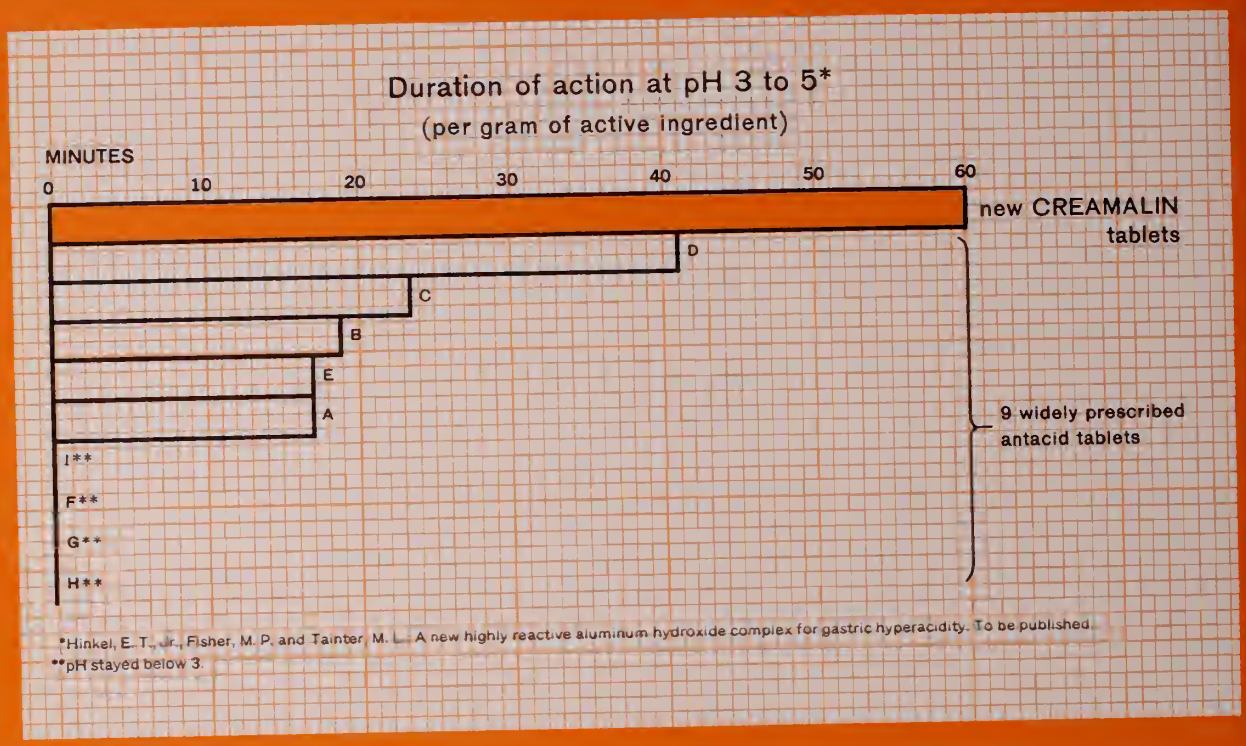


Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain the pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

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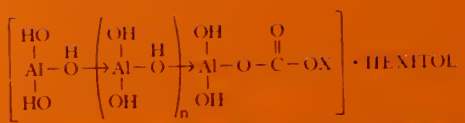
*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highy palatable, soft, smooth, easy to chew, mint flavored.

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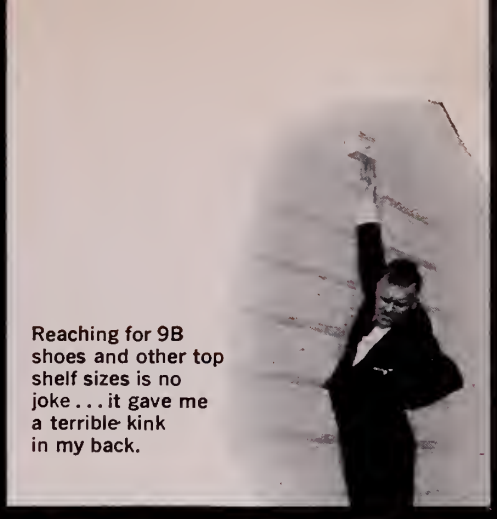
Adult Dosage: Gastric hyperacidity — 2 to 4 tablets as necessary. Peptic ulcer or gastritis — 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

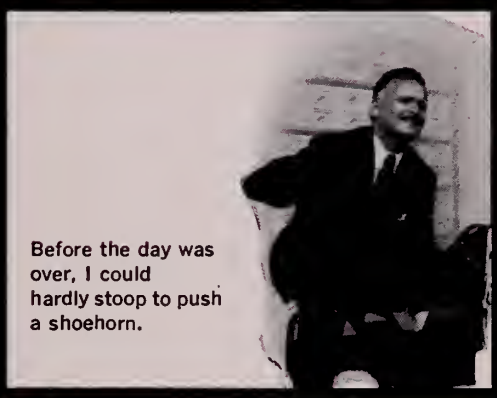
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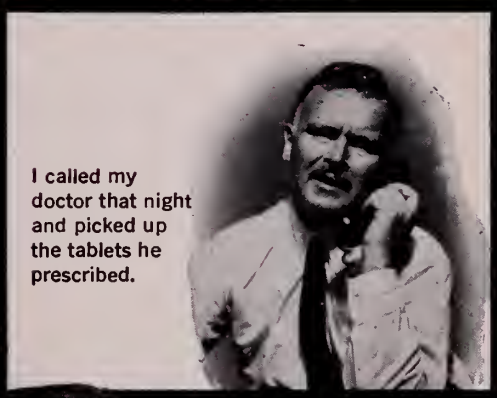
REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



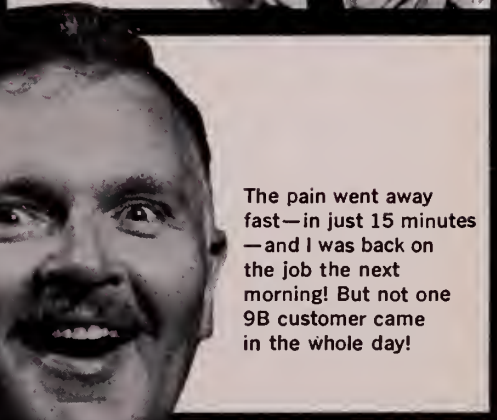
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Before the day was over, I could hardly stoop to push a shoehorn.



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The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

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Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

AND THE PAIN WENT AWAY FAST

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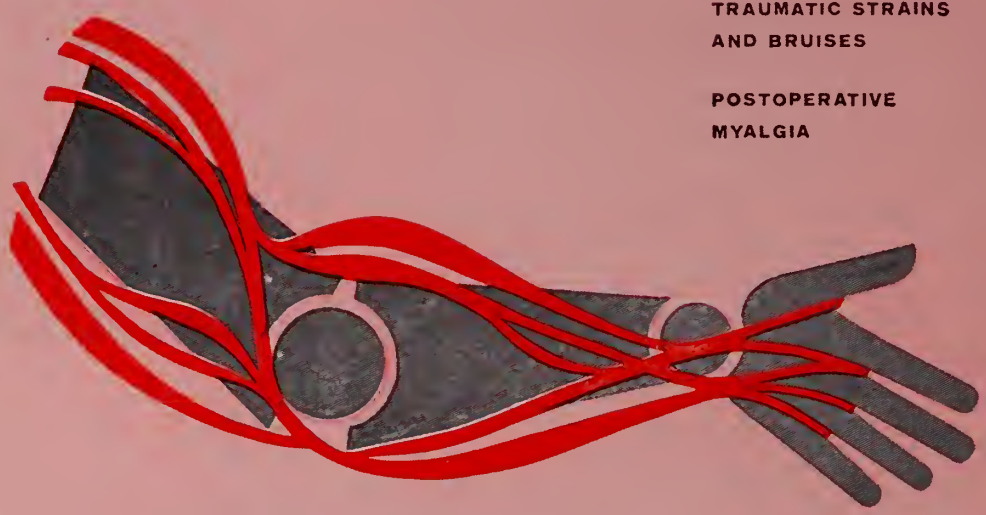
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. . . a new way to relieve pain and stiffness in muscles and joints

INDICATED IN:

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SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

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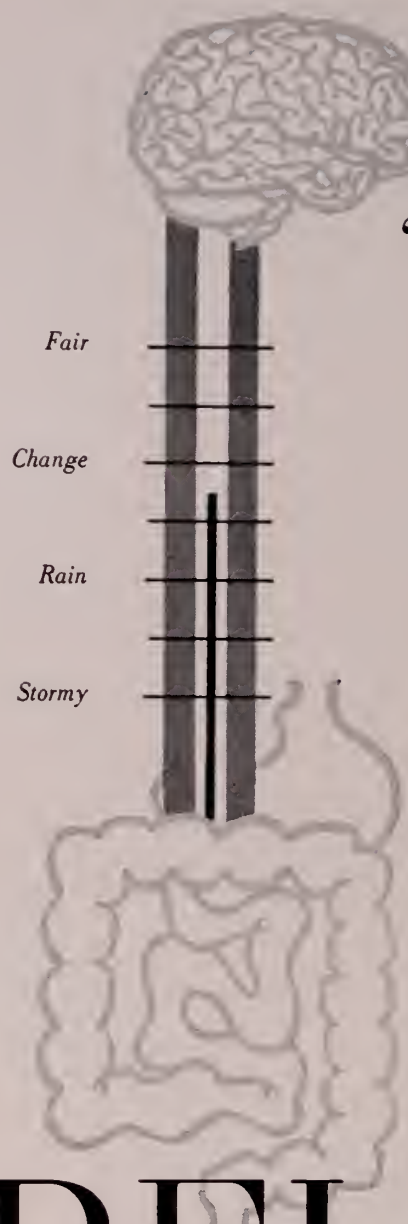
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SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

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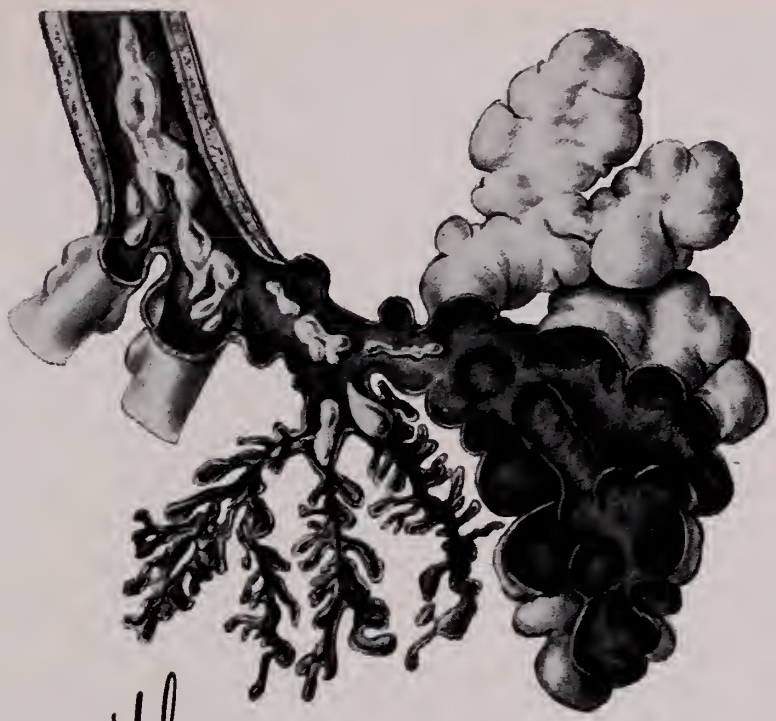
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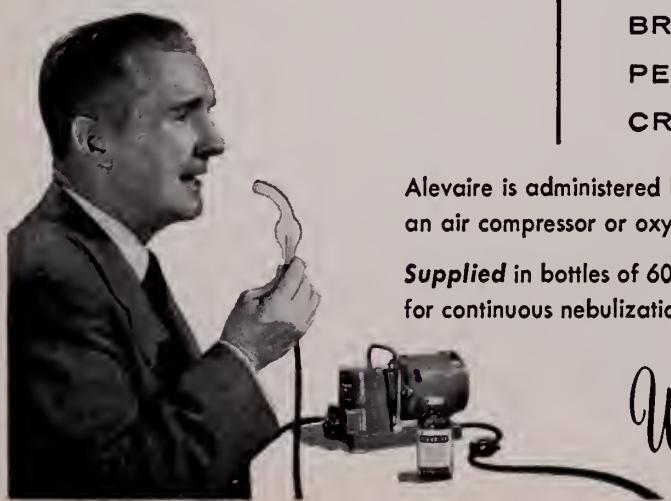
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Very useful in...

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(Continued from page 1340)

Copit, Paul Stanford, Philadelphia (Temple U. 1952)
Corrill, Edgar Martin, Beckley, West Va. (U. Cinn. 1941)
Cottrell, William Wilson, West Palm Beach (U. Louisville 1958)
Cox, John Mark, (Col.), Tuskegee, Ala. (Col. Med. Evangelists 1943)
Crane, George Joel, Miami (U. Geneva 1956)
Cross, Ralph Edgar, Johnson City, Tenn. (U. Tenn. 1942)
Cytowic, Edmund Richard, Trenton, N. J. (Hahnemann 1947)
Dam, Michael Edward Jr., Jacksonville (Marquette U. 1958)
Darrow, Robert Stewart, Tarpon Springs (U. Oklahoma 1939)
DeConna, Theodore John, Pennsauken, N. J. (Hahnemann 1956)
Dickinson, Thomas Coston, Atlanta, Ga. (Emory U 1954)
Dippy, Walter Edward, Orlando (Emory U. 1958)
Dominguez, Jose Ramon, Daytona Beach (U. Havana 1952)
Donelan, G. Lynn, Miami (Temple U. 1956)
Donovan, Francis Connor Jr., Miami (Georgetown U. 1958)
Duany, Antonio Jose, Tampa (U. Havana 1948)
DuPuy, Samuel Stuart, Coral Gables (Med. Col. Virginia 1938)
Eavey, James Lee, Baltimore, (U. Maryland 1946)
Ebbinghouse, Joseph Charles, Jacksonville (Indiana U. 1954)
Eitzman, Donald Vern, Gainesville (St. U. Iowa 1954)
Ellis, Charles Thomas, Hialeah (U. Miami 1957)
Erickson, Alexander John Jr., Coconut Grove (Temple U. 1951)
Fadem, Jerold Joseph, Miami (Missouri U. 1958)
Falconer, Hugh Scott, Temple, Texas (U. Miami 1958)
Falk, Gerald David, New York (New York U. 1957)
Fields, Herbert, Philadelphia (Hahnemann 1958)
Fishkoff, Daniel, Miami (Cornell U. 1957)
Fogel, Norman Allen, Miami (Jefferson 1958)
Fortunoff, Stephen, Philadelphia (Tulane U. 1958)
Franklin, Norman, Pittsburgh (Med. Col. Virginia 1957)
Gant, George Albert, Austin, Texas (U. Miami 1958)
Gargano, Fredie Patrick, Miami (G. Washington U. 1952)
George, Charles William, Jacksonville (U. Tenn. 1958)
Gersing, Albert, Atlanta, Ga. (Emory U. 1958)
Gilbert, Gordon Joel, New Haven, Conn. (New York U. 1957)
Giles, Conrad Leslie, Ann Arbor, Mich. (U. Michigan 1957)
Gilmer, Raymond Evans Jr., Birmingham, Ala. (Alabama Med. Col. 1958)
Glen, Robert Story, Gainesville (Leland Stanford U. 1954)
Goddard, Ralph Andrew, Miami (Boston U. 1957)
Goethals, Paul Lawrence, St. Petersburg (Stritch Sch. Med. 1958)
Goldrich, James Stewart, Cleveland Heights, Ohio (Ohio St. U. 1956)
Goldstein, Morton Lawrence, Pittsburgh (U. Pittsburgh 1957)
Goulard, Alexander Jr., East Norwich, L. I., N. Y. (Jefferson 1948)
Grabb, William Clarence, Ann Arbor, Mich. (U. Michigan 1953)
Granowitz, Samuel Phillip, Pittsburgh (U. Pittsburgh 1958)
Gray, James Alva, Miami (Tulane U. 1958)
Habeeb, Edna Marie, St. Petersburg (Woman's Med. Col. Penn. 1950)
Haber, Mordecai, Hollywood (Tufts 1933)
Hancock, William Roy, Decatur, Ga. (Med. Col. Georgia 1948)
Hanfling, Stanley Martin, Miami (Cornell U. 1955)
Harper, Clarence Herman, Jacksonville (Emory U. 1957)
Harper, John Masters, Jacksonville, N. C. (U. Michigan 1956)



Uneventful Recovery

the pattern of

GLUCOSAMINE-POTENTIATED TETRACYCLINE

therapy

COSA-TETRACYN*

capsules
125 mg., 250 mg.

oral suspension
orange flavored, 2 oz. bottle, 125 mg. per teaspoonful (5 cc.)

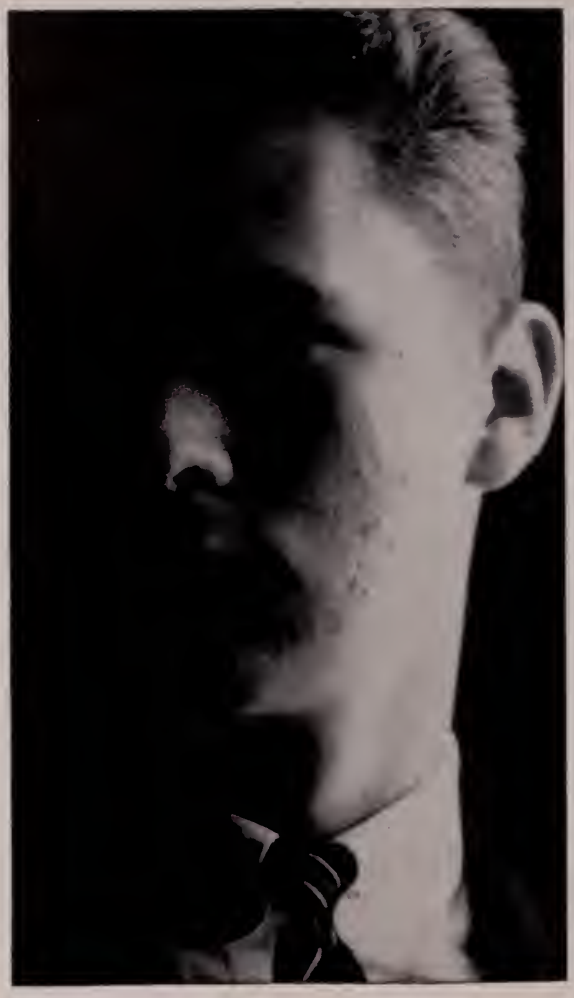
pediatric drops
orange flavored, 10 cc. bottle (with calibrated dropper), 5 mg. per drop (100 mg. per cc.)

Note: Rapid and high initial antibiotic blood levels are an important factor in uneventful recoveries. Glucosamine potentiation provides the fastest, highest tetracycline levels available with oral therapy. Bibliography and professional information booklet available on request.

Pfizer *Science for the world's well-being*

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*Trademark for glucosamine-potentiated tetracycline



in Acne

Routine cleansing with pHisoHex augments standard acne therapy. "No patient failed to improve."[1] pHisoHex helps check the infection factor in acne. Used exclusively and frequently, it will keep the skin surface virtually sterile. Contains 3 per cent hexachlorophene.

pHisoHex®

(antibacterial detergent, nonalkaline, nonirritating, hypoallergenic)

tips the balance for superior results

Winthrop LABORATORIES New York 18, N.Y.

1. Hodges, F. T.: GP 14:86, Nov., 1956.

Harris, Stanley Irving, Bronx, N. Y. (Yale U. 1958)
Harrison, William Vanbrooks, Ormond Beach (New York U. 1950)
Heggie, John Francis, Ridgewood, N. J. (Columbia U. 1955)
Herman, Gerald Paul, Miami (U. Chicago 1958)
Hester, Frederick Cummins III, Mobile, Ala. (U. Miami 1958)
Hewitt, James Carlisle, Tampa (South Carolina Med. Col. 1958)
Hoefle, Harold Harry Jr., Maxwell AFB, Ala. (McGill U. 1955)
Hoff, Theodore Francis, Orlando (U. Kansas 1952)
Hofmann, Alan Frederick, Longboat Key (Johns Hopkins 1955)
Holtzman, Saul Charles, St. Petersburg (Boston U. 1943)
Hood, Bobby Joe, St. Petersburg (Tulane U. 1958)
Hope, Sherman Allen, Panama City (U. Oklahoma 1957)
Horland, Ephraim, Hollywood (U. Zurich 1936)
Howard, Robert Clifton, Jacksonville (U. Miami 1958)
Hutington, Sterling Hicks, Miami(Albany Med. Col. 1946)
Jackson, Thomas Mendel, West Palm Beach (U. Tenn. 1955)
Janower, Murray Lee, Detroit (Wayne St. U. 1958)
Jennings, Clark William Jr., Tampa (Tulane U. 1954)
Jensen, Adrian Richard, Roslindale, Mass. (U. Minn. 1946)
Johnson, Robert Armstrong, Jackson, Miss. (Vanderbilt U. 1957)
Johnson, William Vernon, Tampa (U. Louisville 1958)
Jones, Jenner Garnett, Orlando (Washington U. 1927)
Kaiser, Frank Fremont Jr., Buffalo (New York U. 1948)
Karpas, Charles M., Miami (New York Med. 1952)
Katz, Philip, Fort Thomas, Ky. (Ohio St. U. 1931)
Katz, Sidney, University Heights, Ohio (Tulane U. 1958)
Kaufman, Raymond Earl, Lake Worth (U. Louisville 1957)
King, Robert Lee Jr., Pensacola (U. Minn. 1946)
Klein, Robert Edward, Gainesville (Bowman Gray 1951)
Knowles, Albert Carnes, Bradenton (U. Miami 1958)
Koenig, Marvin Irwin, Miami (St. Louis U. 1958)
Korn, John Thomas, Miami (U. Buffalo 1958)
Kyle, Michael Andrew Whiting, Ind. (Indiana U. 1958)
Langford, George Curtis Jr., Bridgeport, Conn. (U. Miami 1958)
Lee, Joe Hunter, Merritt Island (Louisiana St. U. 1955)
Leitheiser, Karl Arthur, Clearwater (Georgia Med. Col. 1952)
Letchworth, George Wallace, Dade City (U. Miami 1958)
Lewis, Alvin Russell, Birmingham, Ala. (U. Michigan 1954)
Linstruth, Kenneth Albert, St. Petersburg (Albany Med. Col. 1954)
Lipinski, Stanley Wnuk, Lakeland (Northwestern U. 1951)
Lomas, Richard Wilson, New York (Western Reserve U. 1957)
MacDonald, Donald Ian, Jacksonville (Temple U. 1958)
McAllister, Marianna, Miami (U. Tenn. 1957)
McGinty, James Jerome, Gainesville (U. Rochester 1955)
McKee, Duncan Malloy, Baltimore (Vanderbilt U. 1949)
Mandell, Arnold Joseph, New Orleans (Tulane U. 1958)
Mann, Hartley James, Pittsburgh (U. Pittsburgh 1955)
Marsh, Albert Peter, Brooklyn (New York U. 1955)
Mauzy, Merritt Clifford, Ann Arbor, Mich. (Indiana U. 1944)
May, John Albert, Miami (Bowman Gray 1955)
Mazzola, Vincent Pontorno, Booklyn (Long Island Col. Hosp. 1923)
Messenger, George Paul Jr., Miami (Marquette U. 1958)
Meyer, George John, Opa Locka (U. Rochester 1952)
Michael, Max Jr., Jacksonville (Harvard 1939)
Miller, Edwin Bert, Jacksonville (Col. Med Evangelists 1958)
Miller, George Henry Jr., Gainesville (U. Penn. 1948)
Miller, Herbert Adlai Jr., Tampa (U. Miami 1958)
Milligan, Alexander Denholm, Savannah, Ga. (Queen's U. 1933)

(Continued on page 1370)

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

CM 8633

THE HEART DISEASE PATIENT NEEDS RELIEF FROM EMOTIONAL STRESS



ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."
(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.

(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

Miltown®

meprobamate (Wallace)

Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE* (Miltown 200 mg. + PETN 10 mg.).

Miltown causes no adverse effects on heart rate, blood pressure, respiration or other autonomic functions.

*TRADE-MARK CM-8275

WALLACE LABORATORIES, *New Brunswick, N. J.*



in vaginitis

IMPROVED

TRICOFURON®

destroys all 3 *principal pathogens*

Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

Rx NEW BOX OF 24 SUPPOSITORIES WITH APPLICATOR FOR MORE PRACTICAL AND ECONOMICAL THERAPY.

NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

EATON LABORATORIES, NORWICH, NEW YORK



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn

only one Schering Repetab will give your patient

NONSTOP RELIEF FROM NEW YORK TO ISTANBUL



When you prescribe medication in convenient REPETAB form, one REPETAB taken just before his jet flight leaves New York's Idlewild Airport will give your patient the benefits of the first full dose almost as swiftly as his plane soars up and out over the Atlantic. He'll enjoy a single, sustained high therapeutic level for up to 12 hours as his modern plane carries him smoothly over the 5,009 miles. And he can relax until he settles down to shish kebab at Pandeli's 12 hours later....That 12-hour flight to Istanbul is just over the horizon. Modern, dependable REPETABS are here now!

You can prescribe these Schering products in REPETAB *form*

CHLOR-TRIMETON® REPETABS, 8 and 12 mg.
Chlorprophenpyridamine Maleate

TRILAFON® REPETABS, 8 mg.
perphenazine

POLARAMINE* REPETABS, 6 mg.
dextro-chlorpheniramine maleate

PRANTAL® REPETABS, 100 mg.
diphemanil methylsulfate

GYNETONE® REPETABS, .02 and .04 mg.
combined estrogen-androgen

DEMAZIN® REPETABS, 4 mg.
Chlor-Trimeton plus phenylephrine

symbol of the one-dose convenience you want for your patient

REPETABS,® Repeat Action Tablets.

PROMPT REPETAB RELIEF · LASTS ALL DAY OR NIGHT ·

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SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY

*T.M.

5-111

new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions

Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

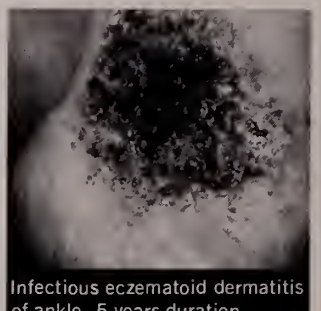
antipruritic/anti-inflammatory/antibacterial/antifungal



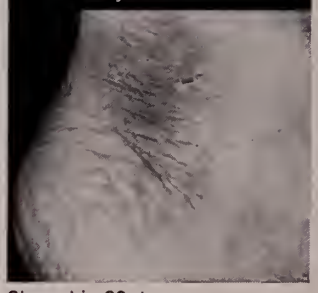
Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

SQUIBB

Squibb Quality — the Priceless Ingredient

'SPECTROCIN'®, 'MYCOSTATIN'®, 'PLASTIBASE'®, 'MYCOLOG' AND 'KENALOG' ARE SQUIBB TRADEMARKS

Antivert® stops



VERTIGO

VERTIGO

Each ANTIVERT *tablet contains:*

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.[2,3]

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

Roerig Rx

Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.
Science for the world's well-being

HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

REPORT ON TRIAMCINOLONE

J.A.M.A. 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone: i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"...the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

Aristocort®

Triamcinolone LEDERLE

Supplied: 1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

B. I. D.

ULCER CONTROL

all day

NEW

DARICON*

oxyphencyclimine hydrochloride

TABLETS

all night

patient comfort

Natural Prolonged Action—The action of DARICON, a more potent and better tolerated anticholinergic, is consistently prolonged because it has a unique chemical structure and is not dependent on "mechanical" means (e.g., special coating, adsorption on ion-exchange resin).

In addition to peptic ulcer, DARICON is also indicated for other gastrointestinal disorders characterized by hypersecretion, hypermotility and spasm (e.g., functional bowel syndrome, chronic nonspecific ulcerative colitis and biliary tract disease).

Dosage: 10 mg. b.i.d. (morning and evening). **Supply:** Tablets, 10 mg., white, scored. Bottles of 60 and 500.

*Trademark

EVEN REFRACTORY CASES RESPOND

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES

Division, Chas. Pfizer & Co., Inc.

Brooklyn 6, N. Y.

2½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

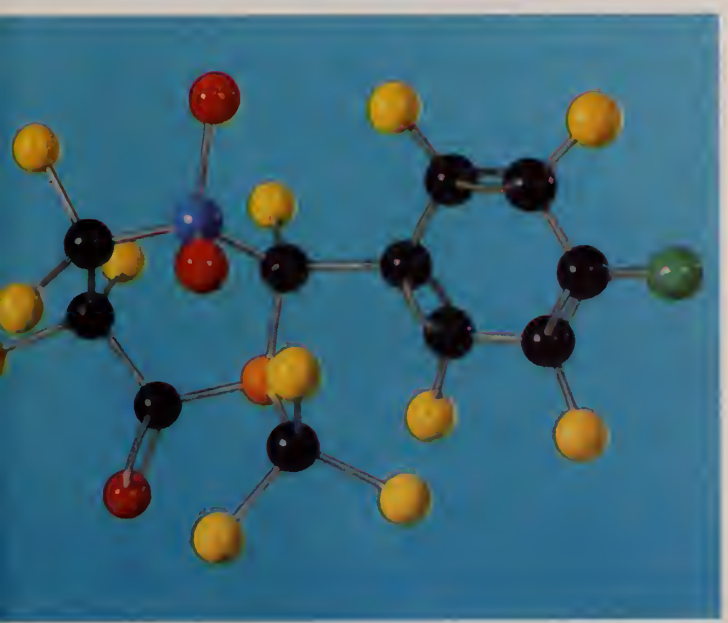
Trancopal®

*the first true tranquilaxant**

***Potent* MUSCLE RELAXANT**

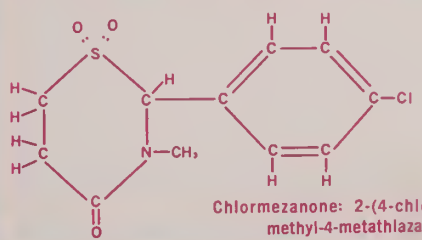
***...Equally effective as a* TRANQUILIZER**

***tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in 91% of patients

INDICATIONS

Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias
Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

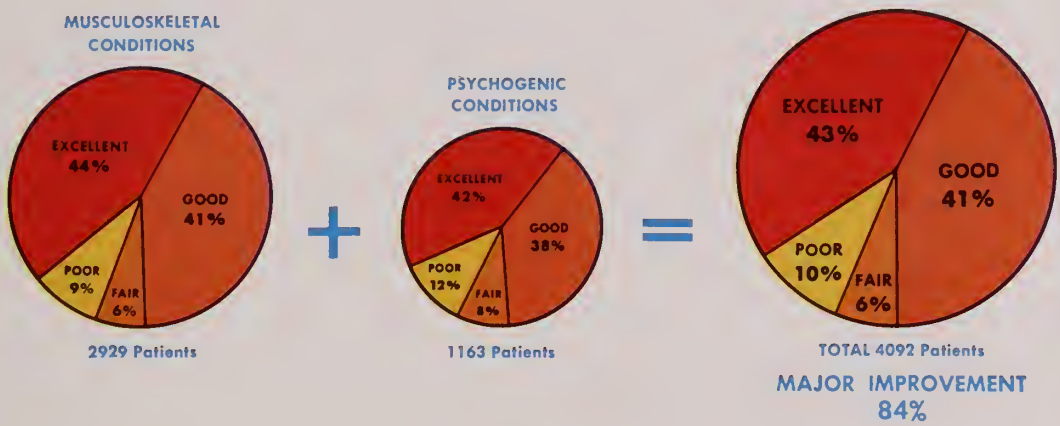
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "...allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



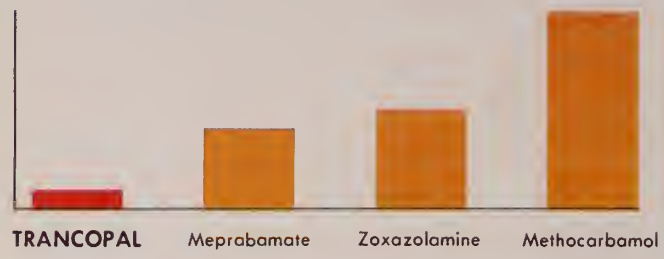
Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage.
Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

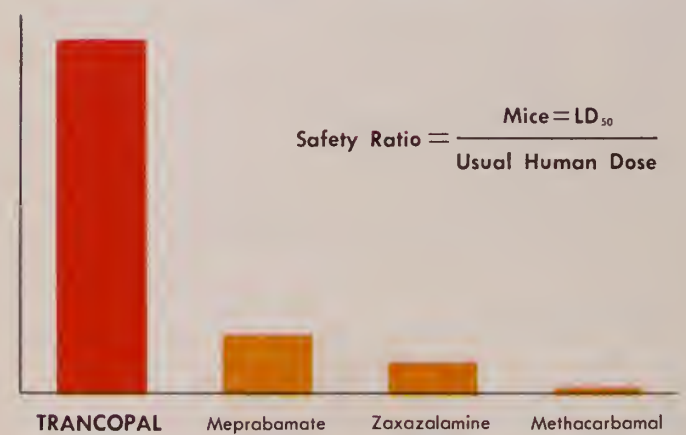
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness. Trancopal offers definite desirable advantages.



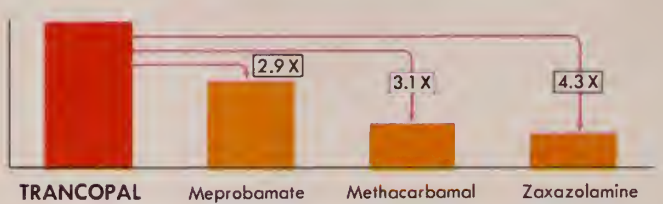
for activity

In the usual human dose, Trancopal is four to ten times as potent per milligram.



for safety

Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of the 40 patients received all four drugs in random rotation for several days. Although each of the four gave some relief, only the one providing the most effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. · 2. Gans, S.E.: To be published. · 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

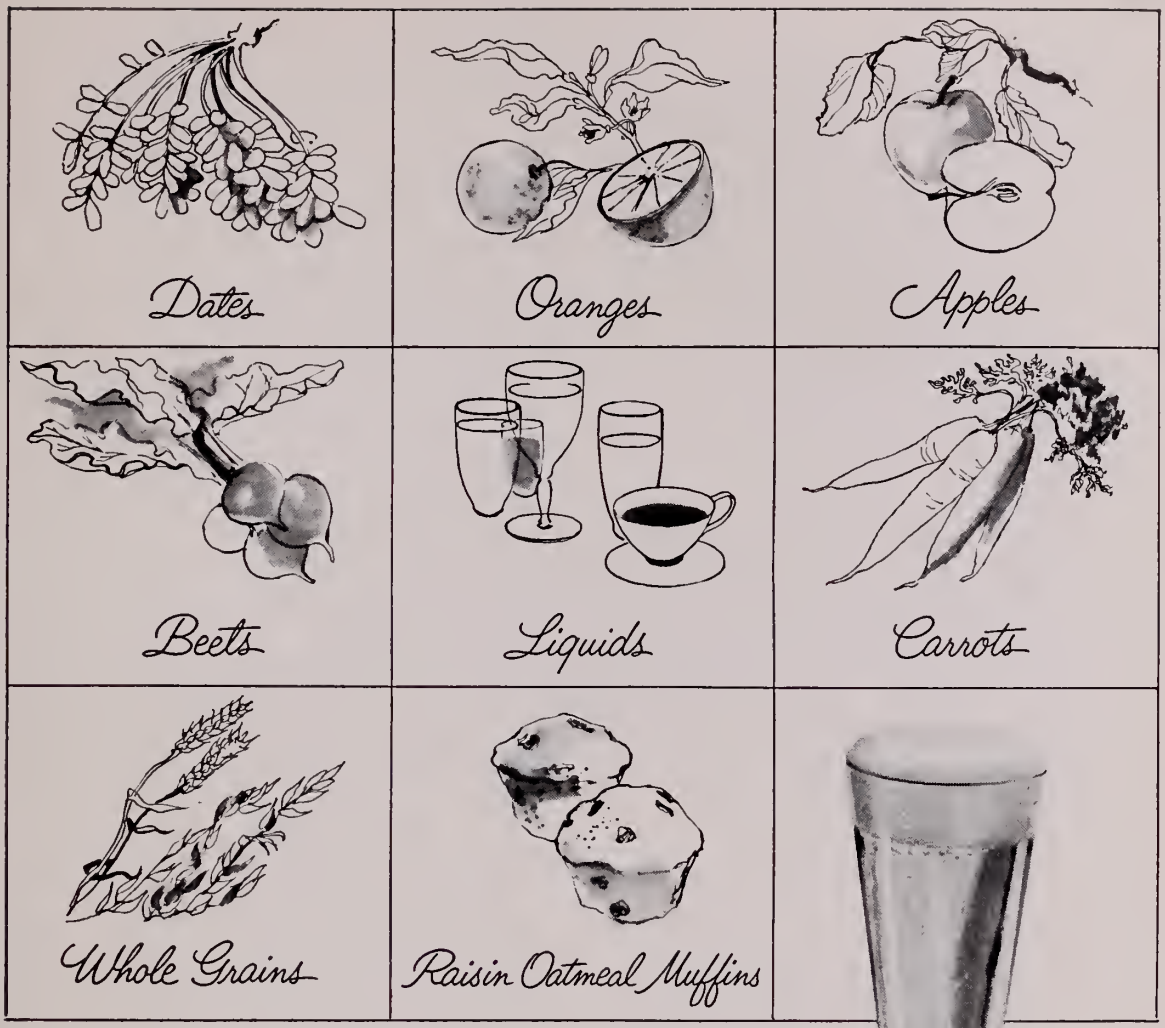
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These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

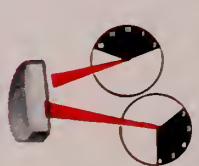
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4, 5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6, 7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

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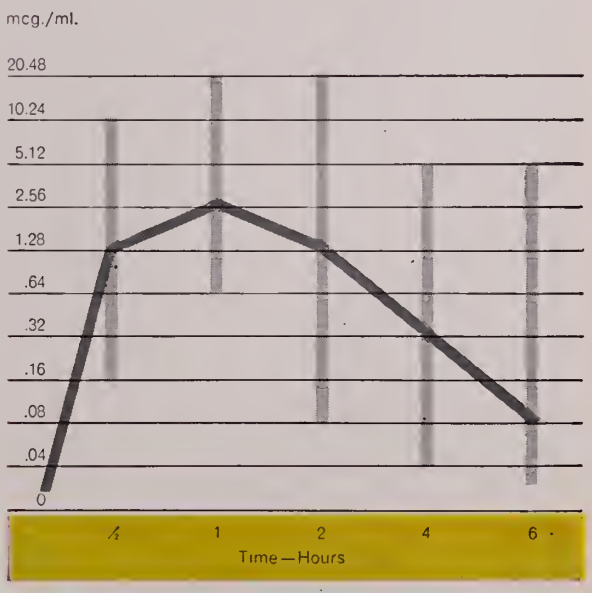
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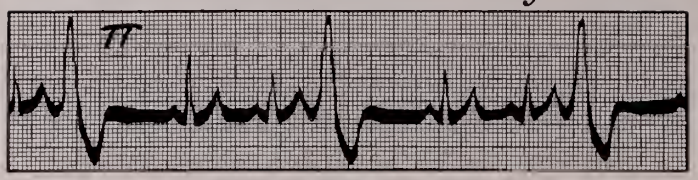
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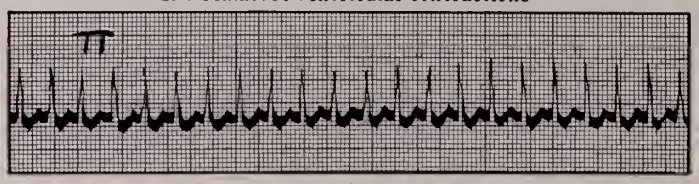


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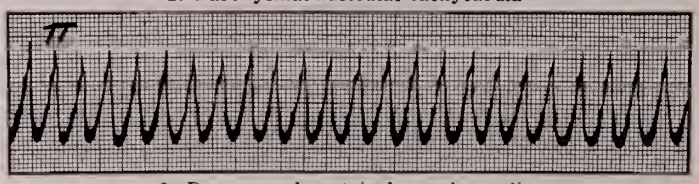
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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

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From Escambia County Comes Our New President

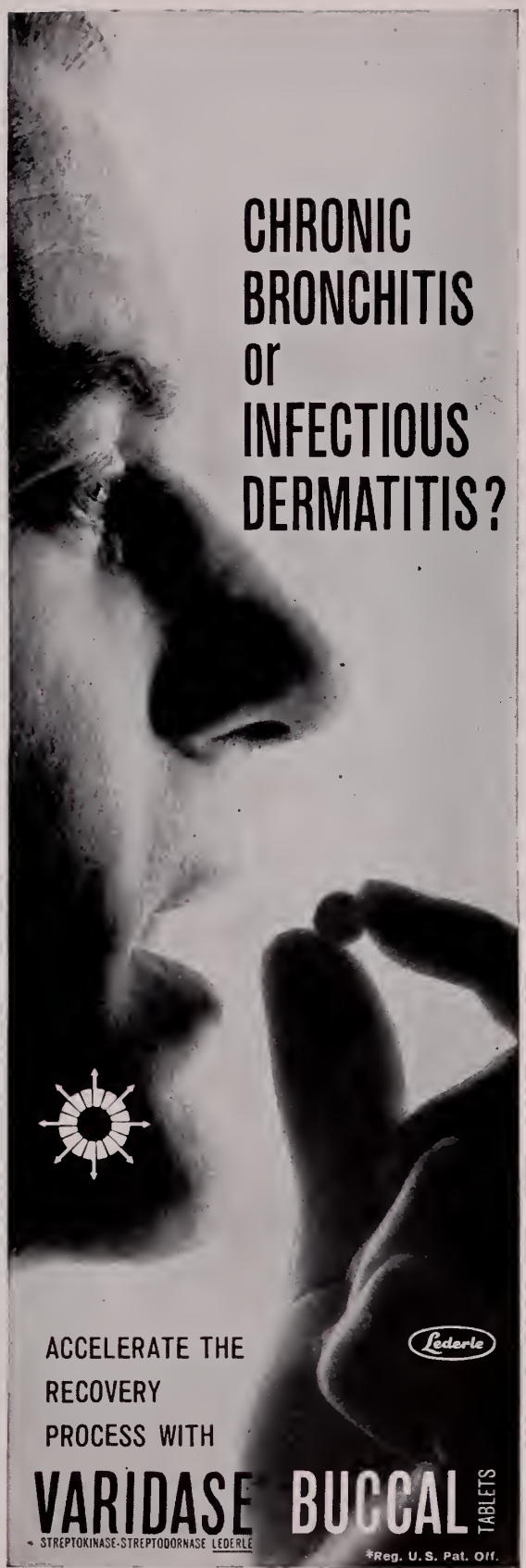
A year of successful Auxiliary work draws to a close under the capable leadership of Ann Rogers. In my appointed position as writer for The Journal of the Florida Medical Association for my first article one year ago, it was my pleasure to introduce Ann. Now as time moves on and new officers take over from the old, my 'Swan Song' as writer, I would like to introduce a new President.

It has been fun doing these monthly articles this year, and I hope in some way the Auxiliary has benefitted from some of the things I have tried to stress. I feel confident that great progress has been made in the state and already I look forward to bigger and better accomplishments for the new year.

For the first time in many years, the President of the state Auxiliary for 1959-1960 will be from Escambia County. She is Mrs. Wendell J. Newcomb, Pensacola, who, by way of background, served as President of her own county Auxiliary in 1954-55 and as Recording Secretary for two years. The state Auxiliary work rests in capable hands for this year and I am sure she will move forward to accomplish great things for us.

On the professional side, Norma holds a Bachelor of Science degree in chemistry, and is a graduate of the University of Nebraska Medical School of Technology. It was while she was at the University that she met Dr. Newcomb, then a medical student. They were married in 1941 during his internship. Dr. Newcomb is now a Fellow of the American Academy of Orthopedic Surgeons. They have four children, Wendell Jr., 16; Vicky, 13; Donald, 7, and Ward, 4.

Norma has been an active garden club member and is a junior judge. She hopes to complete the courses required to become an accredited judge at some future date. She has served as editor for the garden club magazine, Camellia, for two years. She has been active in Cub and Girl scouting but at present has become inactive in all phases of club work to devote full time to the Auxiliary.



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Besides gardening, she enjoys horses, golf and informal entertaining. The Newcomb's now live on Bayou Texar where they are in the process of remodeling and adding a new wing.

With quiet confidence, Norma takes over as President. We, who have come to know her in the past years of Auxiliary work, along with many friends in Escambia County, watch with pride as she goes forth to devote a year of real service to the Auxiliary.

Mrs. Albert F. Stratton Jr.

(Continued from page 1350)

Mimnagh, William Patrick Jr., Pompano Beach (New York Med. 1953)
Mishkin, Marvin Robert, Biloxi, Miss. (U. Illinois 1955)
Mooney, Douglas Parker, West Palm Beach (Ohio St. U. 1956)
Mora, Miguel Angel, North Miami Beach (U. Havana 1946)
Morris, William Alexander III (Col.), Tallahassee (Meharry 1957)
Mummery, Charles Ramond, Miami (Temple U. 1958)
Murphy, Edward Joseph, Wynnewood, Pa. (Jefferson 1944)
Natof, Herbert Erwin, Pottstown, Pa. (U. Illinois 1954)
Orlick, Arnold Henry, Miami (Jefferson 1953)
Paar, James Albert, Hartford, Conn. (Duke U. 1952)
Pacheco, Ferdie, Miami (U. Miami 1958)
Palmerton, David Ludlow Jr., Buffalo (U. Buffalo 1955)
Panos, Maesimund Banning, St. Petersburg, (Ohio St. U.) 1957)
Pettengill, Howard Wakefield Jr., Coral Gables (U. Miami 1958)
Popp, Edward M., Tampa (U. Arkansas 1958)
Privitera, Michael Russell, Buffalo (U. Buffalo 1934)
Rasmussen-Taxdal, David Samuel, Baltimore (U. Maryland 1952)
Ray, Joseph Byron, Dothan, Ala. (Alabama Med. Col. 1958)
Rees, Terry Taylor, Tampa (Tulane U. 1955)
Reinmuth, Oscar McNaughton, Key Biscayne (Duke U. 1952)
Repola, Kenneth Louis, Coral Gables (U. Michigan 1946)
Rhea, Karl Byington, Memphis, Tenn. (U. Tenn. 1954)
Rieth, George Raymond Jr., Lake City (U. Nebraska 1952)
Roberts, Henry Lamar, Gainesville (Duke U. 1944)
Rodda, Thaddeus Salter, Fort Myers (U. Tenn. 1949)
Roll, Harold, Baltimore (U. Maryland 1958)
Root, Allen William, Philadelphia (Harvard 1958)
Rosenthal, Stanley Donald, Fort Dix, N. J. (U. Virginia 1954)
Ross, Glenn Venable, Miami (St. U. Syracuse 1958)
Rywlin, Arkadi Michael, Miami Beach (U. Geneva 1949)
Saab, Joseph Richard, Lackawanna, N. Y. (U. Buffalo 1934)
Santini, Gaetano, Bronx, N. Y. (U. Rome 1945)
Sapp, James Winston Jr., Havana (Emory U. 1957)
Schessel, Eli Sanford, Miami Beach (Chicago Med. Sch. 1957)
Schmidt, Richard Penrose, Gainesville (U. Louisville 1945)
Schmiege, Gustav Richard Jr., Tampa (Temple U. 1958)
Schrader, Wayne Harold, Miami (U. Minn. 1958)
Schultz, Everett Hoyle Jr., Gainesville (Bowman Gray 1952)
Schwartz, Jerold, New York (New York Med. 1956)
Shane, Louis Littman, Philadelphia (Hahnemann 1958)
Shephard, Juddson Elbert, Columbus, Ohio (U. Michigan 1943)

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Shirley, Hoke Harold Jr., Miami (Tulane U. 1958)
Silver, James Allen, Miami (U. Minn. 1958)
Slaton, Paul Ernest Jr., Madisonville, Ky. (Vanderbilt U. 1957)
Smiley, Francis Jones, Memphis, Tenn. (Georgia Med. Col. 1956)
Smith, Arthur Gene, Hazard, Ky. (Syracuse U. 1950)
Smith, James Mervin, Tallahassee (Temple U. 1942)
Smith, Richard Thomas, Gainesville (Tulane U. 1950)
Snow, John Wesley, Washington, D. C. (Duke U. 1955)
Snyder, William, Miami (Columbia U. 1958)
Solomon, O. David, St. Petersburg (U. Pittsburgh 1958)
Spann, William Joseph, Jacksonville (Vanderbilt U. 1948)
Stage, James Henry, Miami (U. Michigan 1954)
Steinberg, Joel Stuart, Miami (Emory U. 1958)
Stickley, Joseph Hardin, Atlanta, Ga. (U. Tenn. 1947)
Stokes, Joseph Bailey Jr., Ocala (Bowman Gray 1958)
Strauss, Raymond Bernard, Cleveland, (Western Reserve U. 1958)
Stults, Robert Harvey, Kingston, N. J. (Western Reserve U. 1958)
Sudarsky, Raymond David, Hartford, Conn. (Yale U. 1949)
Talbert, Wilmier Melvin Jr., Miami (Washington U. 1956)
Talbot, William Armour, Atlanta, Ga. (Emory U. 1957)
Taxay, Emil P., Daytona (U. Cinn. 1954)
Tindel, Seymour, Miami (St. U. New York 1957)
Todd, Ethan Ogilvie Jr., Jacksonville (South Carolina Med. Col. 1953)
Toler, Earle Quillian, East Point, Ga. (Emory U. 1956)
Toole, Rex Foster Jr., Marianna (U. Miami 1958)
Travis, David Monroe, Gainesville (Vanderbilt U. 1951)
Treloar, Hugh Sandeman Budd, Galveston, Texas (U. Miami 1958)
Turkel, Robert Arthur, Miami (Tulane U. 1958)
Turnipseed, Derrick Chadwick, Newport, R. I. (Emory U. 1937)
Urquiola, Joaquin, Tampa (U. Havana 1945)
Veenstra, Kenneth Earl, Tampa (U. Michigan 1955)
Waid, Margaret Elizabeth, Gainesville (U. Michigan 1948)
Wallfield, Mark Joseph, Brooklyn (Columbia U. 1925)
Walzer, Richard Arnold, Eglin AFB (Columbia U. 1956)
Weill, Hans, Miami Beach (Tulane U. 1958)
White, Thomas Robert, Princeton (Emory U. 1958)
Williams, Royce Mahone, Tampa (U. Tenn. 1957)
Willner, Robert Erwin, Clovis, N. M. (New York Med. 1955)
Wise, Melvin Shally, Daytona Beach (Tulane U. 1957)
Wolfram, Charles Gordon, Miami (Tulane U. 1958)
Woodson, Dan Earl, Gainesville (U. Tenn. 1957)

OBITUARIES

Joseph Edward Thomas

Dr. Joseph Edward Thomas of Plant City died at Bay Pines Veterans Administration Hospital on Dec. 31, 1958, of leukemia after a short acute illness. He was 37 years of age. Interment took place in San Lorenzo Cemetery in St. Augustine.

Born in Studa, Pa., on Oct. 30, 1921, Dr. Thomas received his academic education at John Carroll University in Cleveland, Ohio, where he was awarded the B.S. degree in 1944. He attended Georgetown University School of Medicine in Washington, D. C., receiving the M.D. degree from that institution in June 1948. After interning at St. Elizabeth's Hospital in Youngstown,

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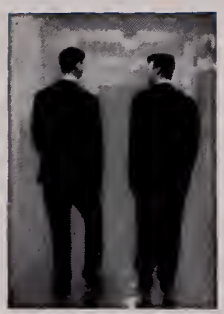
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Ohio, he took surgical residency training there for a year, at St. Vincent's Hospital in Jacksonville for a second year, and later at St. Thomas Hospital in Nashville, Tenn., for two years, where he served as chief surgical resident.

Dr. Thomas was licensed to practice medicine in Florida in January 1951 and first engaged in private practice in Mulberry. After a tour of duty in the Air Force during the Korean conflict and the completion of his residency training, he returned to Florida. In February 1957 he located in Plant City and engaged in active general surgical practice in that area until the time of his last illness. Locally, he was a member of St. Clement's Catholic Church and the Holy Name Society.

A member of the Hillsborough County Medical Association, Dr. Thomas also held membership in the Florida Medical Association and the American Medical Association. He was a diplomate of the American Board of Surgery.

Dr. Thomas is survived by his widow, the former Martha Janice Masters of Jacksonville and St. Augustine; four sons, Edward, Paul, John and Stephen Thomas; his parents, Mr. and Mrs. John T. Thomas of Plant City; two brothers, Dr. William Thomas of Houston, Texas, and John Thomas of Miami; and one sister, Mrs. Anne Dowling of Miami.

BOOKS RECEIVED

Emergency War Surgery. *U. S. Armed Forces Issue of NATO HANDBOOK Prepared for Use by the Medical Services of NATO Nations.* United States Department of Defense. Pp. 411. Price, $2.25. Washington, D. C., Superintendent of Documents, U. S. Government Printing Office, 1958.

This book is a revision of a manual developed at Supreme Headquarters, Allied Powers Europe (SHAPE), prepared under the aegis of the Assistant Secretary of Defense (Health and Medical) for the joint use of the U. S. Army, Navy, and Air Force. Designed to fit the pocket of the field uniform, it is compact and concise, and is also extremely practical. It covers the care of casualties in forward areas, from the battlefield to field and evacuation hospitals. The principles and practices described, however, are well adapted to the management of trauma which is so much a part of modern civilian life. Even before distribution had been accomplished, half a dozen professors of surgery in medical schools had announced the adoption of this book for their courses in traumatic surgery.

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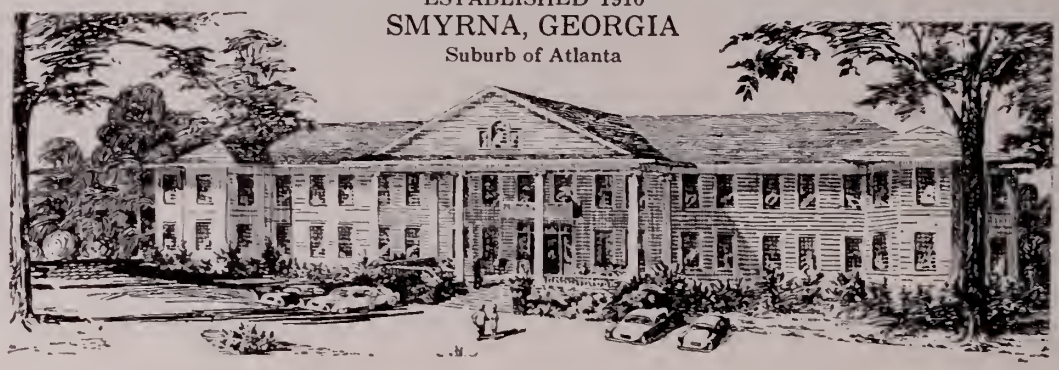
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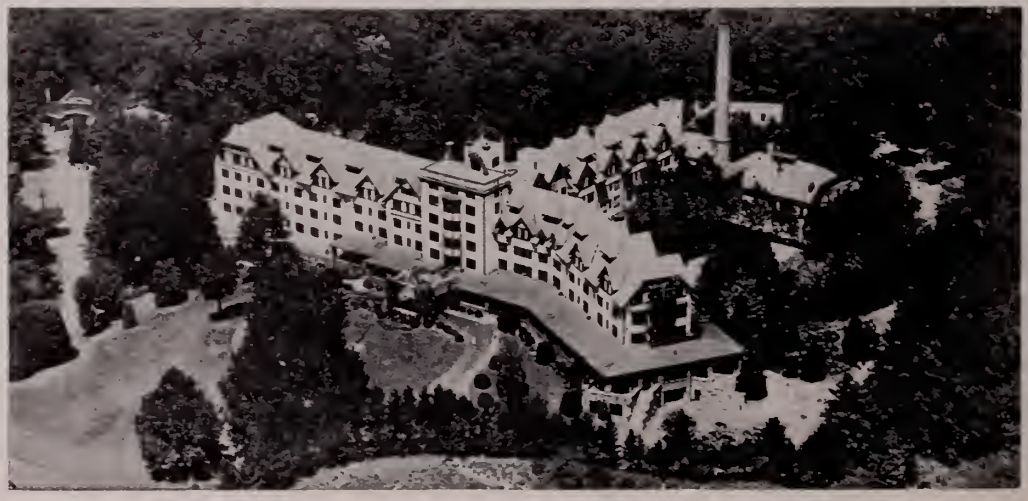
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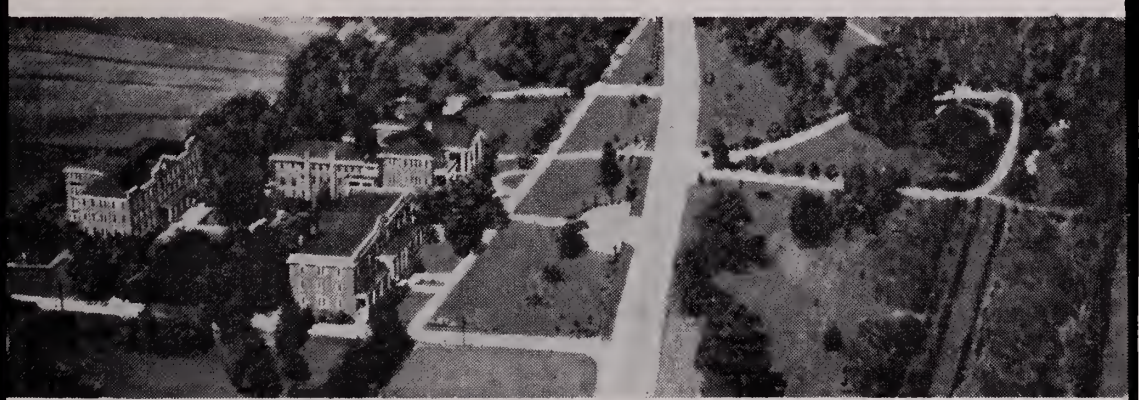
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Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	31
Brevard	Louis C. Jensen Jr., Cocoa	Carl J. Arnold, Cocoa	1st Tues.	59
Broward	Miles J. Bielek, Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	2nd Tues.	223
Collier	John J. Meli, Naples	Ethel H. Trygstad, Naples	4th Tues.	12
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	920
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	355
* *Clay*				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	115
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	234
Indian River	B. Bowman Guerin, Vero Beach	Phil D. Morgan, Vero Beach	2nd Tues.	11
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	29
* *Sumter*				
Lee-Charlotte-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	Quarterly	75
Madison	Thomas G. Bouland Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	33
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	36
* *Levy*				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	8
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	232
* *Osceola*				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	178
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	291
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	125
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	11
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	28
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	82
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	16
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	7
* *Dixie*				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	90
* *Flagler*				
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				3,465

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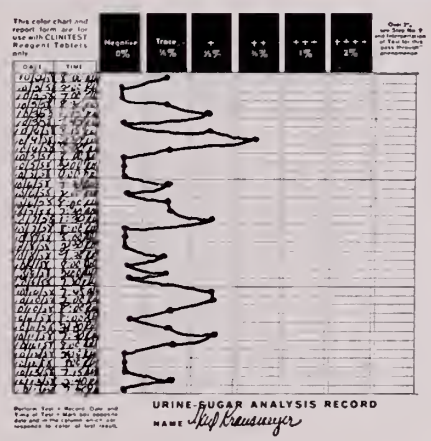
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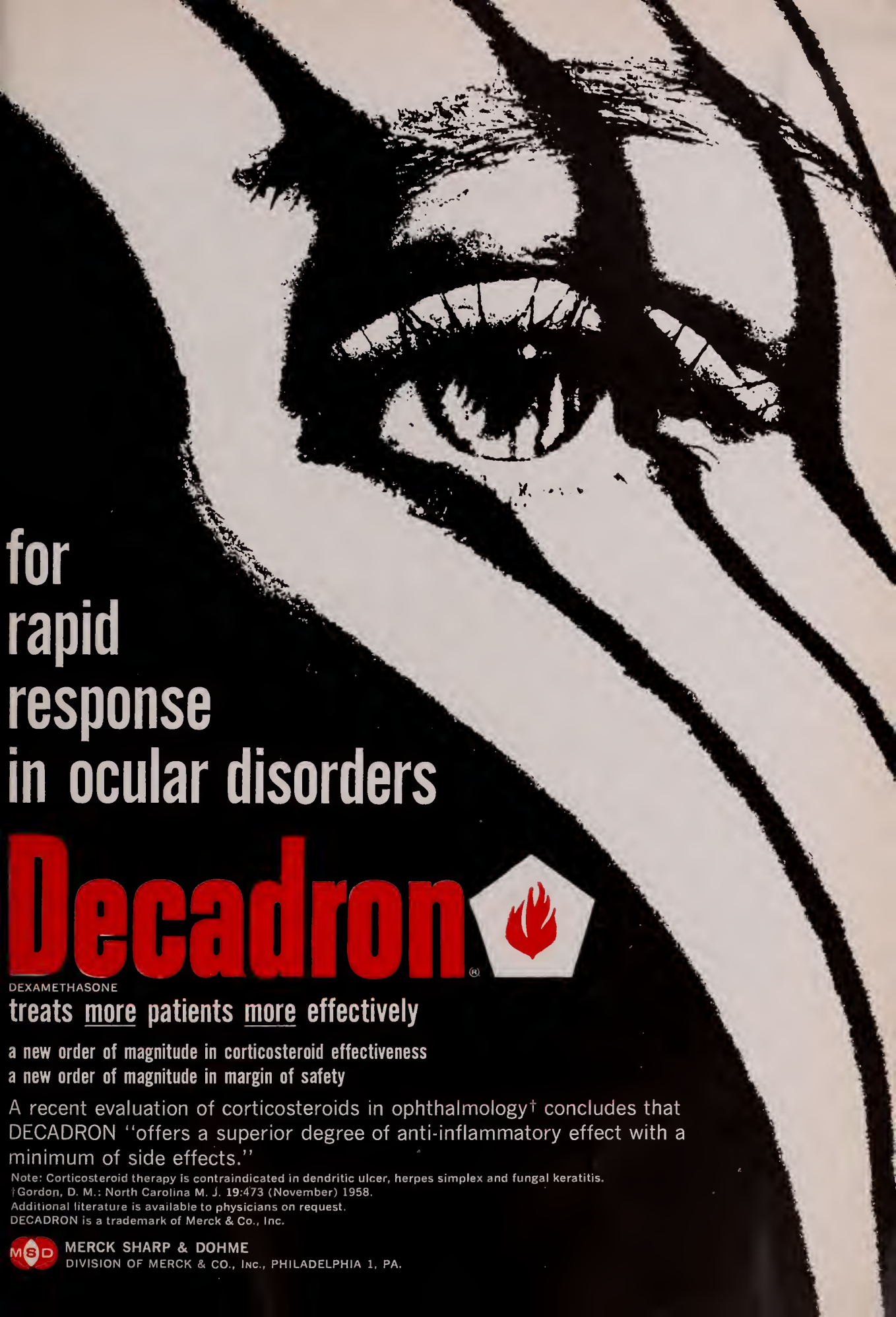
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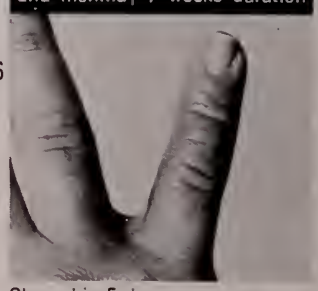
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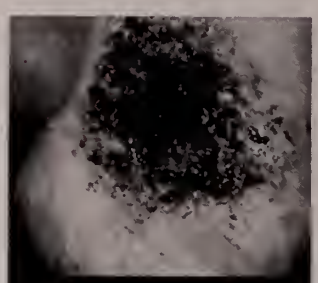
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References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

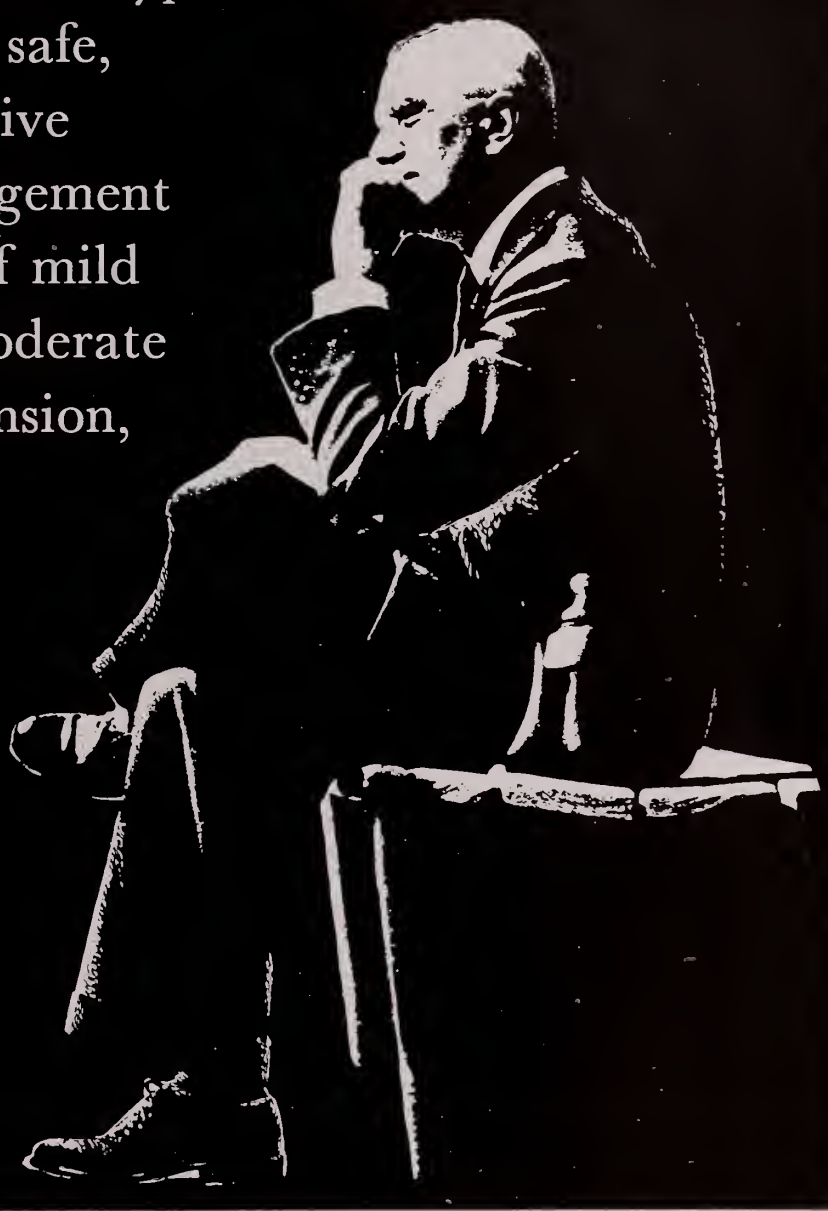
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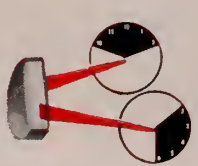
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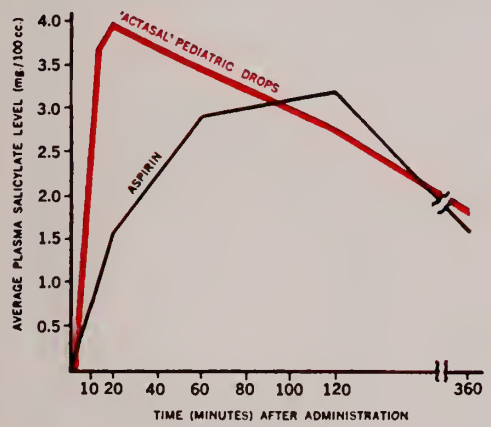
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CITED REFERENCES: 1. Smith, P. K.: Personal Communication. 2. Wolf, J., Aboody, R.: Federation Proc. 18:605, 1959. 3. Broh-Kahn, R. H.: Federation Proc. 18:17, 1959. 4. Complete data available on request to the Medical Director.

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Bialkin, G.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959.

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Bialkin, G.: A New Anti-Seborrheic Agent in Pediatric Practice. Arch. of Ped. (to be published).

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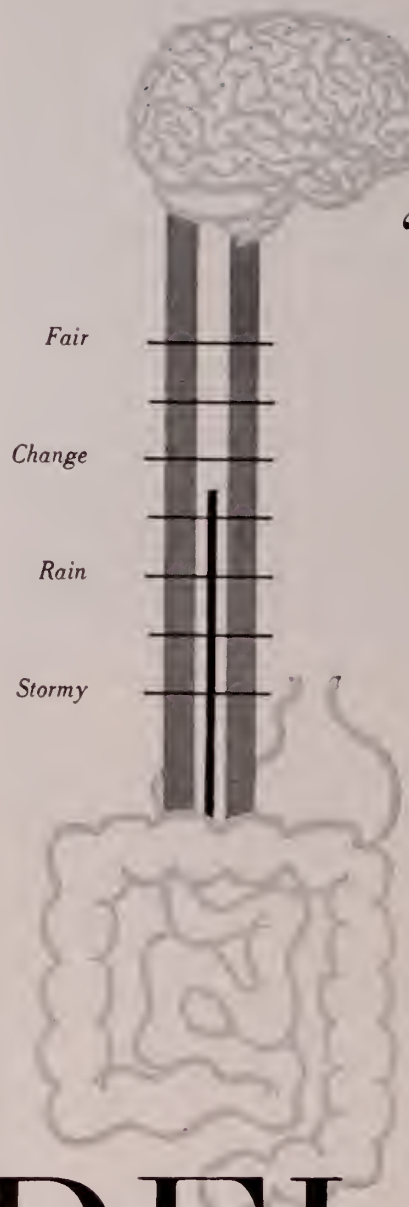
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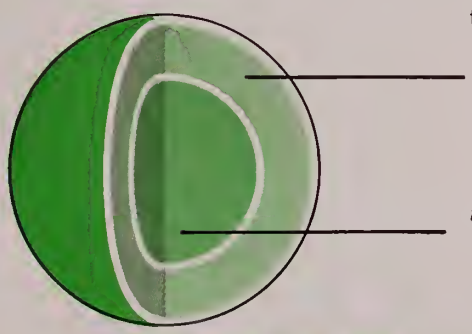
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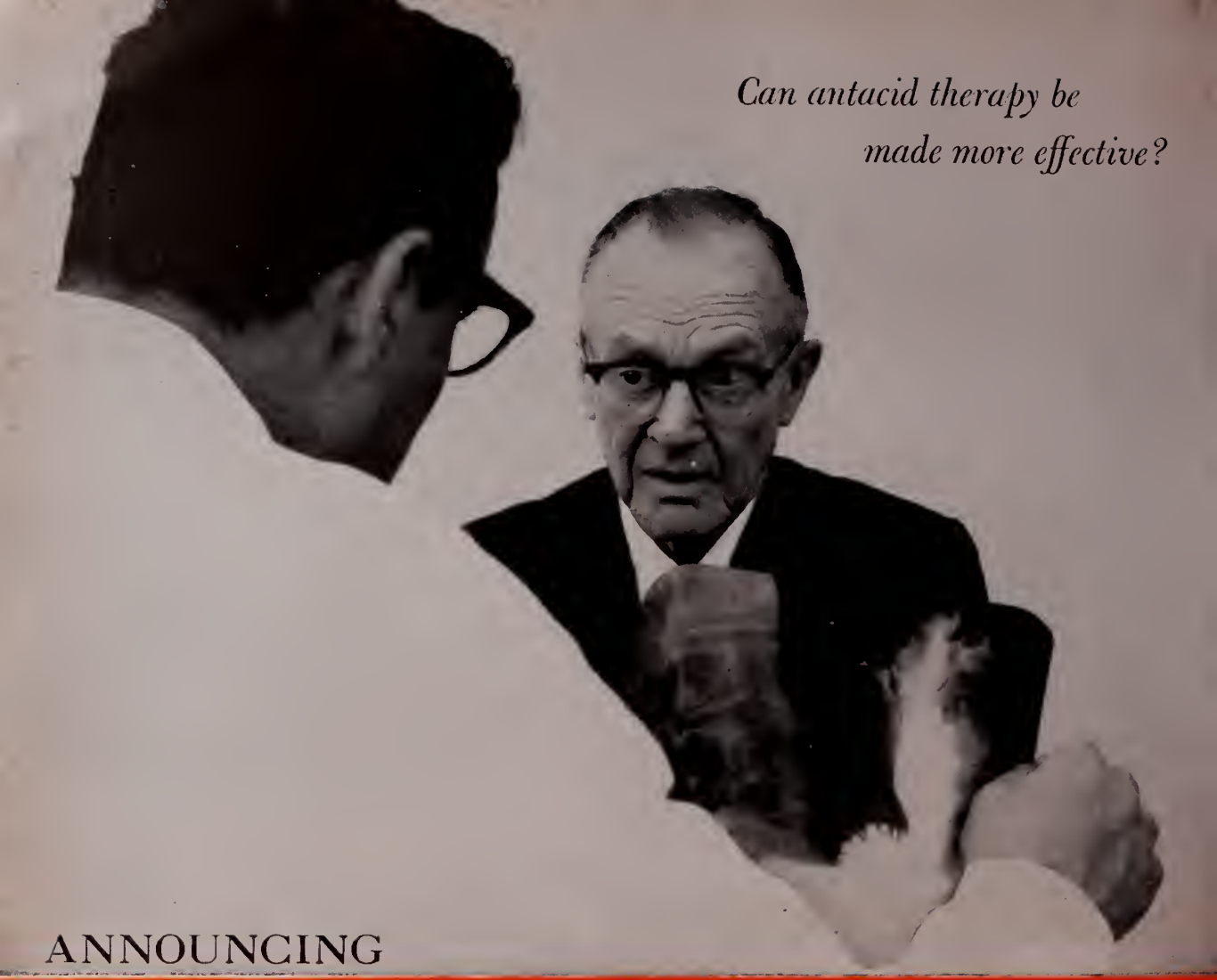
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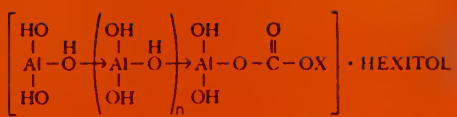
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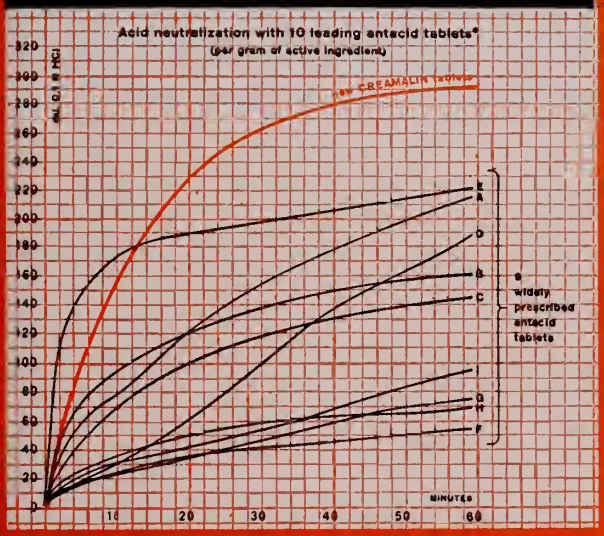
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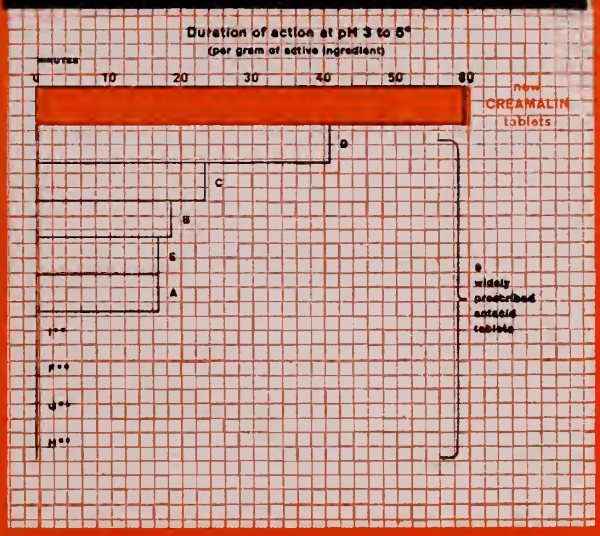
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Pulmonary Surgery in Infants And Children

Hawley H. Seiler, M.D.
TAMPA

Surgical procedures involving the lungs are particularly well tolerated in infants and children in most instances. This was not always the case. The past decade has seen many advances which have contributed to the increased safety of pulmonary surgery in this age group. These include improvements in diagnostic methods, better anesthesia, more careful attention to and a better understanding of preoperative and postoperative care, and the judicious use of antibiotic drugs. There has also been progress in the further refinement of various surgical technics. The art of medicine plays an extremely important role in the handling of these young people. As Potts[1] aptly expressed it, "An operation done on a 150-pound adult is not divided by a factor of 15 when one is operating on a 10-pound child. An adult can be treated as a child but never a child as an adult."

Close cooperation with the pediatrician or family physician is essential. The importance of mental preparation of the child cannot be overemphasized. It is wise to explain to him, without going into detail, that his illness requires certain special treatment. Much can be done by means of a simple, pleasant conversation with the youngster to allay his fears and to gain his complete confidence.

The importance of thorough preoperative preparation of the patient is well recognized. This includes correction of anemia, appropriate antibiotic therapy, thorough bronchial toilet, and the like. Blood for transfusion should be matched and ready prior to surgery. In most instances, it is wise to do a "cut-down" before the operation is started, especially in infants and smaller children. This may seem time-consuming, but is often time well spent and time saved in the long run.

Of paramount importance in the postoperative period is satisfactory nursing care. It must be remembered that small infants and young children cannot tell of their needs. Unattended postoperative vomiting can have immediate fatal results. Postoperative complications are predominantly respiratory in nature, and great attention must therefore be paid to maintaining an adequate airway. A suction apparatus must be immediately available at all times. Tracheostomy is occasionally indicated in cases with tenacious, retained tracheobronchial secretions.

Proper antibiotic therapy is, of course, continued during the postoperative period. Oral feeding can usually be satisfactorily resumed within eight to 16 hours. Children tend to return to normal quickly, resume normal diet in a short time, and can be ambulated as soon or sooner than adults in most cases.

The present communication concerns experience in the treatment of various pulmonary lesions requiring surgical intervention. In the time allotted, it will be possible to discuss only certain selected conditions and to cover the field in only a cursory manner.

Lung Cysts and Pneumothorax

The discovery of a radiolucent area in the lung field of an infant or child presents an important problem in differential diagnosis and therapy. Such an abnormality may be observed in the course of routine roentgen studies or may be associated with respiratory symptoms. Conditions which may give rise to such a roentgenographic appearance include congenital tension cysts, lobar

Read before the Florida Medical Association, Eighty-Fourth Annual Meeting, Bal Harbour, May 13, 1958.



Fig. 1. — Congenital pulmonary cyst in a three year old boy. Treated by local excision (enucleation technic).

or localized hypertrophic emphysema, infectious pneumatoceles, pneumothorax, and diaphragmatic hernia. The congenital cyst seen during the first days of life, though rare, usually presents a surgical emergency. These are often large tension cysts resulting in progressive dyspnea, cyanosis, and tachycardia. Such cysts are usually confined to one lobe, and curative lobectomy can be accomplished in many instances.



Fig. 2. — Persistent congenital (?) spontaneous pneumothorax in a one year old boy. Treated by decortication and satisfactory re-expansion of the lung.



Fig. 3. — Agenesis of the right lung in a 15 year old girl. Treated by surgical excision of secondarily infected rudimentary structure.

When such cysts are seen beyond the period of early infancy, they do not as a rule present the same degree of urgency and symptoms are not severe unless secondary infection occurs. When these cysts do become infected, surgical removal is indicated. In one such personal case, it was possible to remove the wall of the large infected cyst by simple enucleation following spontaneous evacuation of its infected contents through the bronchus.

Pneumothorax in an infant or child may be the result of rupture of a pre-existing cyst or emphysematous bleb, or may occur following trauma or an infectious process such as pneumonia. Pneumothorax of this type may be localized or extensive, and may or may not be associated with a significant degree of atelectasis. Needle aspiration or closed catheter drainage will usually effect a cure. In certain instances, however, thoracotomy will be required to close a persistent air leak or to perform decortication if the lung fails to re-expand following conservative measures.

Agenesis of the Lung

Agenesis of the lung is an extremely rare lesion and one difficult to diagnose until the specimen is examined by the pathologist. Roentgen studies reveal an opaque hemithorax. Such a roentgenographic appearance could result as well following atelectasis from an inflammatory stricture, foreign

body, or tumor obstruction. Angiocardiography is of value in demonstrating the presence or absence of the pulmonary vessels.

Personal experience with this condition is limited to one case of a 15 year old girl. A severe secondary infection was present and prior to surgery it was thought the problem was an extensive abscess with destruction of the whole lung. At the time of exploration the structure found did not resemble lung, but rather a dense, ill-defined mass with no recognizable vascular pedicle and a rudimentary, obliterated main bronchus.

Bronchiectasis

Bronchiectasis in children, though not common, is by no means rare. Indeed, bronchiectasis in adults occurs more frequently in the younger group and commonly has its origin as a childhood illness. This condition is without doubt reversible in certain instances, but there is usually a definite tendency towards recurrence and chronicity of the disease. Although the pathologic lesions of bronchiectasis may remain a more or less localized process involving one or more lobes, the disease not infrequently shows a definite tendency to extend to other portions of the same or opposite lung in spite of all treatment. Gross[2] stated, "Bronchiectasis rises slowly out of the smoldering ashes of some previous pulmonary insult or a long-continued pulmonary inflammation."

Among the more common etiologic factors may be listed unresolved pneumonia, atelectasis, allergic conditions, chronic sinusitis, foreign body, repeated episodes of bronchitis and other respiratory infections, severe pertussis, and abnormalities of the bronchial tree such as congenital cystic disease or mucoviscidosis. In one instance under personal observation, weakness or lack of tracheobronchial cartilage resulted in compensatory emphysema of considerable degree, repeated respiratory infections with associated bronchiectasis, and eventual funnel chest.

Simple ectasia of the bronchial tubes without symptoms is not considered an indication for surgical intervention. In those children who present localized symptomatic bronchiectasis, however, with recurring episodes of bronchial obstruction, surgical removal of the involved area will usually result in great improvement if not complete cure. Inflammatory bronchostenosis proximal to the area of bronchiectasis may occur with resulting segmental lobar atelectasis. This combination of atelectasis and bronchiectasis constitutes a definite indication for surgical intervention.

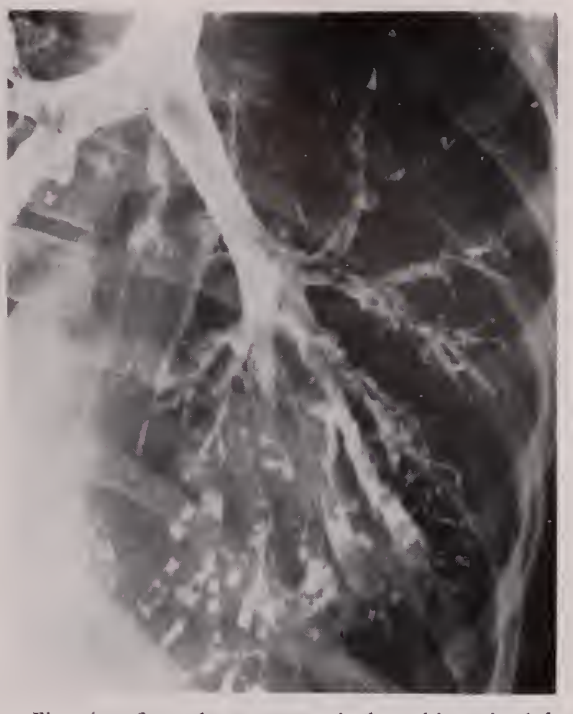


Fig. 4. — Severely symptomatic bronchiectasis, left lower lobe (spot film), in a seven year old boy. Treated by left lower lobectomy.

Before a decision concerning surgery is reached, thorough evaluation of the patient should be carried out and should include bronchoscopy and bronchography. Complete bronchographic mapping is important to evaluate properly the extent of



Fig. 5.—Extensive left lower lobe bronchiectasis in a 12 year old girl. Treated by left lower lobectomy.



Fig. 6. — Chronic, recurring atelectasis and bronchiectasis of the right lower lobe secondary to bronchostenosis, in a three year old girl. Treated by right lower lobectomy.

bronchiectasis in each case and to plan the extent of surgical resection to be performed. Other important measures include postural drainage, intelligent use of antibiotics following sensitivity studies to the predominant organism cultured from the bronchial secretions, aerosol therapy, correction of anemia, and general hygienic measures.

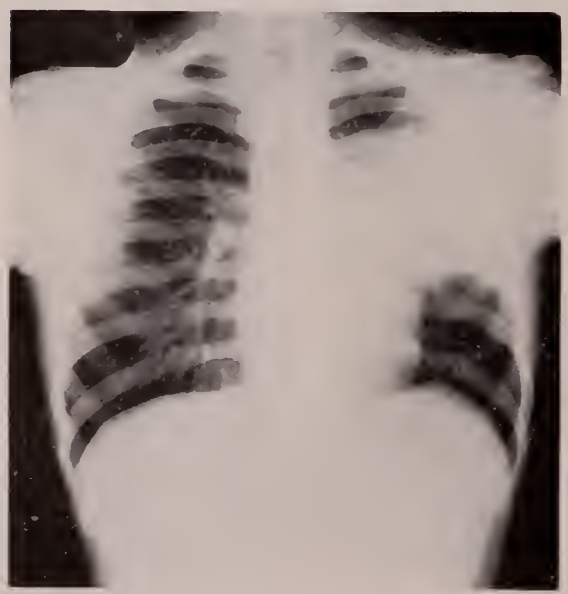


Fig. 7. — Chronic lung abscess in an 11 year old boy following aspiration pneumonia. Treated by left upper lobectomy.

The surgical procedure itself consists most frequently of lobectomy although segmental resection is occasionally sufficient and pneumonectomy may rarely be required. In properly selected cases, the mortality and morbidity should remain low.

Several unusual forms of childhood bronchiectasis are recognized and these may or may not be amenable to surgical treatment. Such a condition is the so-called Kartagener's syndrome consisting of dextrocardia, situs inversus, sinusitis, and bronchiectasis. Bronchiectasis may be extensive in these cases, and does not usually become evident until the child is approaching or is in his teens.

Severe bronchiectatic changes are also seen in cystic fibrosis of the pancreas or mucoviscidosis. This condition is associated with a pronounced disturbance of fatty absorption and is believed possibly to be on the basis of a vitamin A metabolic disturbance. Prognosis in children with this condition often is very poor, and only rarely do they become candidates for surgical treatment of the bronchiectatic component of the disease.

Middle Lobe Syndrome

Atelectasis of the middle lobe of nontuberculous origin with suppurative changes was first described in 1948 by Graham, Burford and Mayer.[3] It was thought this condition was related to the particularly vulnerable location of the middle lobe bronchus in relation to hilar lymph nodes, and that compression from these enlarged nodes was a causative factor in bronchostenosis and nonaeration of the middle lobe. Since this initial report, the condition has been commonly recognized and is now considered a definite pathologic entity.

Clinically, the middle lobe syndrome can be described as a suppurative process which is characterized by repeated episodes of pneumonitis, productive cough, recurrent fever, and frequent hemoptysis. Whereas middle lobe disease begins with bouts of obstructive pneumonitis, it terminates in extensive bronchiectatic changes of the lobe and subsequent destruction of lung parenchyma distal to the point of obstruction. Surgical excision of the diseased middle lobe is usually curative, and pathologic examination of the specimen reveals atelectasis, bronchiectasis, and fibrosis if the disease is sufficiently long-standing.

It is occasionally possible actually to demonstrate significant lymph gland compression at the

time of surgery. An obstructing broncholith was the etiologic factor in one personal case.

Although middle lobe disease is most frequently seen in young or middle-aged adults, it is occasionally encountered in children. If symptoms and repeated episodes of obstructive pneumonitis occur, surgical excision is indicated and can be accomplished with insignificant risk.

Lung Abscess

Abscess of the lung is probably seen with less frequency in infants and children than in adults. Due to the widespread and early use of the various broad spectrum antibiotics, this formerly dread complication of pneumonia is now of infrequent occurrence.

The etiology of abscess of the lung is usually on the basis of previous improperly treated or the end result of severe bronchiectasis or infected refractory pneumonia, foreign body aspiration, cyst, aspiration of vomited material during or following tonsillectomy and other surgical procedures, and an implantation or blood-borne abscess associated with tonsillitis, furunculosis or other pyogenic infections.

The usual medical approach to the treatment of abscess of the lung is not always as effective in children as in adults. This difference is due in large measure to the inability of children to bring up retained secretions properly or to their failure to cooperate in this matter. Much can be accomplished by repeated catheter aspiration of the trachea or by bronchoscopy as an adjunct to the usual medical regimen. In chronic abscess which does not respond to such measures, however, cleancut surgical removal of the diseased lobe is the treatment of choice. There is practically no place in the present day management of abscess of the lung for the drainage procedures employed many years ago.

Proper preoperative preparation with aerosol therapy, postural drainage, and decreasing the amount of secretions is highly important. Even so, administration of anesthesia in such cases may tax the skill of the best anesthesiologist. If secretions retained postoperatively present a problem and the child is unable to cough up his secretions, and if difficulty is experienced in removing such secretions by means of catheter suction, one must not hesitate to perform tracheostomy. With careful attention to all aspects of preoperative and postoperative care, as well as careful anesthesia and surgical technic, the results of surgery in the treatment of this difficult condition should be excellent in nearly all cases.



Fig. 8. — Pulmonary tuberculosis in a two year old boy. Treated by right upper lobectomy following appropriate sanatorium care and antibiotic therapy.

Pulmonary Tuberculosis

Pulmonary resection in adult tuberculosis is a well established procedure and has played a major role in the remarkable progress noted during recent years in the treatment of this disease.

The adult type of tuberculosis with its usual protracted course and chronicity is occasionally observed in children. When this is so, the same principles of treatment that apply in adults are generally acceptable with certain modifications. Judicious use of the various antituberculous drugs represents the most important form of therapy.



Fig. 9. — Dermoid cyst involving the superior segment of the left lower lobe, in a two year old boy. Treated by excision.



Fig. 10. — Foreign body (straight pin) lodged in the left median basal bronchus of a 9 month old girl. Removed by transthoracic approach following unsuccessful attempt at bronchoscopic removal.

During the past decade surgical resection of the destroyed area of lung or residual focus of disease has been applied to children with the same uniformly good results as when applied to adults. Such surgery, of course, is only a part of the therapeutic program and must be well coordinated with sanatorium care and chemotherapeutic and antibiotic treatment. Proper timing of the surgical intervention is of great importance as this therapy should not be carried out in the progressive or highly active stage of the disease. Surgery usually consists of lobectomy or segmental resection for destroyed lobes or segments or residual cavitary and nodular-caseous disease. Decortication may be required to bring about complete re-expansion of the remainder of the lung. Pneumonectomy is undesirable in children but occasionally necessary for complete eradication of the disease.

Complications are probably higher in this group of patients than in infants and childrer subjected to pulmonary resection for other diseases. Bronchopleural fistula may occasionally be expected, for example. This complication can usually be readily overcome by the use of intercostal catheter drainage.

Miscellaneous Conditions

TUMORS.—Tumors, benign and malignant, are only rarely encountered in this younger age group. The teratoma-dermoid group, although arising usually in the mediastinum, may involve the lung. Hamartoma, lipoma, chondroma, fibroma, fibrosarcoma, adenoma, lymphatic tumors and Hodgkin's disease, and carcinoma have all been reported.

Specific and nonspecific granulomas, hemangiomas, and arteriovenous fistulas can occur.

FOREIGN BODIES.—Although the great majority of foreign bodies encountered in the tracheobronchial tree can be removed endoscopically, in certain instances removal in this manner is impossible and open thoracotomy must be performed. It may be far more shocking and damaging to the infant to carry out repeated and prolonged futile attempts at bronchoscopic removal of a foreign body than to remove quickly the offending material by means of rapid and relatively atraumatic thoracotomy. Certain types of foreign bodies, such as a straight pin or other sharp-pointed object, can be simply expressed and removed through the pulmonary parenchyma and the tiny residual hole easily closed with a mattress suture. At other times, open bronchotomy must be performed. This again usually presents no serious technical problem and the main bronchus can be readily and satisfactorily approximated. There has certainly been more than one endoscopic fatality which could have been avoided by judicious and early use of thoracotomy in preference to the repeated trauma of unsuccessful endoscopy.

Tracheostomy

The value of tracheostomy when needed can not be over emphasized. One should never hesitate to proceed immediately with this often life-saving measure if indicated. Too often tracheostomy is withheld until serious respiratory difficulty has occurred. It is much easier to prevent pulmonary congestion and pneumonia by proper tracheobronchial toilet than to cure these complications once they have appeared. Prevention can best be accomplished in a sick or uncooperative child by means of catheter aspiration through a previously placed tracheostomy. The nurse can much more readily aspirate secretions, there is elimination of much dead space, immediate improvement in respiratory effort is noted, and the administration of aerosols to the tracheobronchial tree is facilitated. When the tracheostomy has served its purpose and the tube is removed, there is rapid healing with minimal scar formation. To withhold urgently needed tracheostomy and ponder the question of whether or not it should be done may result in the loss of valuable time with disastrous consequences.

Summary

Certain pulmonary diseases of infants and children are best treated by surgical methods. Surgery in this group of patients is far more satisfactory today than in former years and an excellent result can be expected in the great majority of cases. These little patients tolerate pulmonary surgery surprisingly well and have a resiliency not often encountered in adults. Convalescence is usually rapid. Certain of the more common surgical pulmonary diseases encountered in infancy and childhood are briefly discussed. Surgical technic in these little people involves gentle handling of tissues, the use of finer instruments and finer sizes of suture material, extreme caution in the placement and use of retractors, and close attention to the details of preoperative and postoperative care. Of extreme importance also is expert anesthesia, avoidance of mental trauma in this impressionable young group, and close cooperation between the pediatrician or family physician and the surgeon. If such principles are applied, the results of pulmonary surgery in this group can be expected to be as good or better than comparable surgery in adults.

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Colloidal Oatmeal in Atopic Dermatitis Of the Young

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The purpose of this paper is to present a clinical evaluation of colloidal oatmeal as an adjunct in the treatment of atopic dermatitis. We have included in this study a large group of cases of infantile eczema because of the strong belief of many workers in the field, including Hill[1] and Epstein,[2] that this disease is a form of atopic dermatitis.

The oatmeal preparation used in this study** is obtained by a special milling process involving separation of the colloidal fraction from the whole oat grain. The process is carried out entirely in the cold, in order to avoid any heat deterioration to the colloidal constituents. The product contains 46 per cent oat starch, 24 per cent oat protein, 9 per cent oat oil, 0.03 per cent crude fiber, and 8 per cent moisture. It is presented as a dry stable powder under ordinary storage and is readily miscible in both hot and cold water.[3]

The pH of normal skin is slightly acid, between 4.2 and 5.5. This acidity is a protective mechanism against pathogens and is important in maintaining the integrity of the keratin layer. Inflamed skin, on the other hand, is alkaline. Soap, which has a pH of 9.5 to 10.5, removes this acid covering.[4] The colloidal oatmeal used is slightly acid, too, which would be one of its advantages.

Its high protective colloid activity is demonstrated by its low gold number (Zsigmondy).[5] Its viscosity and surface tension establish a good spreading and clinging property which would be necessary for sustained protective action.[6]

Kierland and Ede,[7] in 1951, reported its use at the Mayo Clinic and thought that it had distinct advantages over the product obtained from the use of cereal oatmeal. They pointed out the ease of preparation in contrast with the long time required for preparation of oatmeal cereal grade, which must be boiled, allowed to cool, and then placed in a gauze bag for use. Further, they observed that explanations to the patient concerning the use of the oatmeal bag are no longer necessary and that the friction produced by the rubbing of the gauze bag on the skin is avoided.

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**The colloidal oatmeal used was AVEENO, manufactured by the Aveeno Corp., New York, N. Y.

Grais[3] used colloidal oatmeal as the sole topical agent in the treatment of 139 patients with common geriatric dermatoses. Approximately 72 per cent of the patients obtained complete or decided relief, and only 4.3 per cent obtained no relief. He thought that this preparation exhibited a remarkable lack of skin-sensitizing and irritating properties, making this agent valuable in avoiding 'overtreatment dermatitis.'

Atopic dermatitis is noted for its chronicity and, at times, its intractable nature. Then, too, the severe pruritus occurring in some of the cases may set up a vicious cycle in which scratching, nervousness and loss of sleep may serve to propagate the disease and make it worse. We thought that this disease would be ideal in evaluating the colloidal demulcent properties of colloidal oatmeal since demulcents are often used in its treatment.

Analysis of Series

The 41 cases in this study were drawn from the private practice of one of us and from the dermatology clinic of The Duval Medical Center outpatient department. The ages of the patients varied from two and one-half months to 18 years, and there were 29 females and 12 males. Thirteen of the patients were one year or less in age. The disease varied in severity from mild involvement of the face to severe generalized involvement of the entire body.

The colloidal oatmeal was used in the form of daily baths or applied locally in the form of cold wet packs. The solution for wet packs was made by adding 1 tablespoon to a quart of water and mixing thoroughly.

In some of the cases it was used as the sole topical agent, but in the majority of the cases it was used in conjunction with other topical and internal medications.

Our results were as follows: in 29 per cent of the cases the dermatitis cleared up completely, in 22 per cent there was great improvement, in 41 per cent some improvement, and in 8 per cent no improvement.

Discussion

We thought that the results obtained with this preparation were excellent and that it represented a valuable contribution to the armamentarium. One of the impressive features of its use was the rapidity with which we obtained results. Results, when they were forthcoming, usually occurred in one to three weeks. In many of the cases in which other medications produced meager or no results, there was rapid improvement when colloidal oatmeal baths were added without any change in the prior medications. The outstanding case in our series was that of a 10 year old girl who had had the disease for many years and who had failed to respond to any therapy until the start of these baths.

In a small group of cases we attempted to run a control series by using plain water on these patients before starting the use of the oatmeal baths. Although the group was too small to draw any significant conclusions, we thought that there was a rapid change for the better in the majority of these cases after the colloidal oatmeal baths were started.

Of the 13 cases in children one year or less in age, excellent results were obtained in seven, some improvement in five and no response in only one. These results are particularly significant when one considers the difficulties involved in treating patients in this age group.

Summary

The physical and chemical properties of colloidal oatmeal as a demulcent are discussed.

A series of 41 cases is presented in which baths of colloidal oatmeal and its local application were used in treatment. This preparation was used in a small number of cases as the sole therapeutic agent.

In 92 per cent of the cases results ranged from some improvement to complete clearing of the disease. In only 8 per cent was there no evidence of improvement. Results, when they were forthcoming, occurred rapidly, usually in one to three weeks.

We think that our results were excellent and that colloidal oatmeal as a demulcent is a valuable addition to the armamentarium used in the treatment of atopic dermatitis.

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Albedocone in Osteoarthritis

(Hesperidin-Methylene-Carboxy-Chalcone)

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Albedocone is a new water-soluble flavanone which has been found highly effective in relieving the pain and stiffness of osteoarthritis.

Osteoarthritis, more correctly called degenerative joint disease, is intimately associated with senescence. It occurs with increasing frequency from the third decade on. Only a small number of persons in whom changes characteristic of osteoarthritis are demonstrated roentgenographically have symptoms in the joints. Roentgen evidence for diagnosis is unsatisfactory as many persons with symptoms who have only soft tissue involvement will have negative roentgen findings.[1] None of the routine laboratory tests are diagnostic.

Several theories have been advanced as to the cause of osteoarthritis. Heredity seems to play a part. Trauma appears to be important. A decrease in blood supply is probably a factor.

The physical findings of pain, stiffness, and tenderness are the diagnostic features. Diagnosis entails ruling out other entities that may involve the joints and simulate osteoarthritis. In the large joints osteoarthritis is twice as prevalent in males as in females, while Heberden's nodes in the terminal phalangeal joints are 10 times as prevalent in females as in males.[1] Osteoarthritis does not tend to cause severe crippling, except when it involves the hip joint; however, it is often a serious nuisance that makes the victim's life miserable. In some cases of long standing in joints that have much trauma there is often considerable wear and disorganization of the joint. This type of case responds poorly to any type of medical or physical therapy.

The effect of Albedocone in osteoarthritis was at first observed as an incidental finding,[2] when a building contractor who had been wearing a corset for two years because of post-traumatic osteoarthritis of the lumbar spine laid his corset aside permanently after he had been treated with large doses of Albedocone for two weeks for other reasons. He continued on this medication for some time afterward, however. Now if he experiences pain in his back, he needs to take only a few Albedocone capsules to stop it. Other patients who had osteoarthritis in various joints were subsequently treated in an attempt to determine its effectiveness and the amount of medication required. In general, those patients with early osteoarthritis and minimal joint damage showed the best improvement with the least tendency for return of symptoms.

This study was made on unselected patients by 12 physicians* working independently in private practice and the Department of Nutrition at the University of Florida. The investigators were a heterogeneous group in that they were a mixture of generalists and specialists. Most of the investigators prescribed Albedocone for at least one patient with rheumatoid arthritis to "see for themselves" that it was not effective. There were 12 such patients and all failed to respond. In addition, three patients with gouty arthritis were given Albedocone without favorable response. These 15 patients served in a useful capacity in that they made a good control group to show that psychologic factors were not important, especially since most of the investigators had at least one of them.

The specialists, like an ophthalmologist who made some of these reports, were treating the patients for other entities, and the improvement in osteoarthritis was an incidental observation. Their attention was usually directed to it by the patient. Such case histories were included only when the patients gave definite and detailed reports that were unsolicited.

The precise manner in which Albedocone brings about improvement in osteoarthritis is not known. It has been shown in other phases of the clinical survey that there is an improvement in circulation.[3,5] In some cases there was an aggravation of symptoms for a few days after starting medication, which was probably due to increased circulation in the involved areas. This was taken as a favorable sign since most of these patients made

The Albedocone for this study was supplied by Tropic Drug Company, Fort Lauderdale.

*Collaborating physicians: George Dormon, Winter Haven; Paul Maas, Pompano Beach; John T. McDermid (deceased), Fort Pierce; William P. Rice, Orlando; and Miles J. Bielek, Julius F. Boettner, E. Borland Gill, Thomas F. Huey Jr., Richard A. Mills, David R. Rogers, and John L. Tomlinson, Fort Lauderdale.

excellent responses. In the laboratory studies it was found that young laboratory animals on moderate doses grew much faster than the controls on the same diet. This rapid growth in addition to the rapid healing of chronic ulcerative lesions in patients taking Albedocone suggests that it is a powerful stimulant to growth and repair.

A most interesting feature of this study is the long period of time that some patients have remained free of pain. Several of them, especially those who had minimal lesions, have had no recurrence. Others had recurrence after several months and again responded to Albedocone when it was resumed. Those with severe joint damage usually got partial relief only while on medication. There is one exceptional group in this study worthy of special mention. A group of older women who were in general "physical wrecks" from osteoarthritis and osteoporosis did exceptionally well considering their physical condition. In some the hands had become so bad that they could write only with difficulty or, in two instances, had not been able to write a letter for a year or more. Now they can write. The pain and much of the stiffness are gone from the fingers. Some had been spending most of their time in bed. They are now up and around much more with little pain. The families of those who were depressed due to cerebral arteriosclerosis commented on their improvement in many cases. Most of the poor results were in patients with extensive joint damage or in patients with heavy psychosomatic overlay due to environment. Two patients who had gastric intolerance and could not take Albedocone were not included in the series.

Analysis of Results

The results were graded in three general groups without attempt at a fine division. They were classed as good, fair and poor.

If the patient became free of pain and tenderness with some increase in joint mobility, the result was classed as good. If the pain disappeared but there was slight residual tenderness, the result was classed as fair. If there was indefinite or no improvement, the result was classed as poor.

Combined in these reports are those from a study that was conducted by the Department of Nutrition at the University of Florida on a colony of retired people to observe the over-all effects of Albedocone on geriatric complaints. In that group 22 patients had the symptomatology of osteoarthritis and were subjected to considerable laboratory work. None of the laboratory studies were productive except in five patients who also had an elevated nonprotein nitrogen due to chronic kidney disease. In each case there was a lowering of the nonprotein nitrogen and an over-all improvement in the general condition of the patient by the end of a month on therapy. This observation had previously been made in another study.[1]

Albedocone was given in capsules of 310 mg. before meals and at bedtime. If there was acute discomfort, the patient was often given two capsules before meals and at bedtime until the acute symptoms subsided.

Taking the patients in age groups, there were:

1. Thirty-nine patients under the age of 50 years in whom the results were

Good in 33
Fair in 4
Poor in 2

Those who responded well have tended to keep their improvement. Their joint damage was on the whole not extensive.

2. Fifty-four patients between the ages of 50 and 70 years in whom the results were

Good in 41
Fair in 8
Poor in 5

Their joint involvement was on the whole more extensive than that in the younger group and the results were corresponding. Generally their improvement corresponded to the degree of joint involvement.

3. Forty-eight patients, 70 years of age and older, composed of 33 women and 15 men, in whom the results were

Good in 34
Fair in 8
Poor in 6

In view of the extensive bone changes in many, especially the women who often had extensive osteoarthritis and osteoporosis, their responses were exceptionally good. Often other symptoms like early senile mental changes and nocturnal leg cramps improved concurrently. The joints in which the results were poorest were in the cervical spine and knees. In the cervical spine it appeared that the patients expected too much increase in motion in joints that were impaired by calcification. In the knees there was often evidence of extensive joint damage; so little could be expected. In some knees other factors in addition to osteoarthritis were suspected.

Summary

Osteoarthritis is a disease associated with wear, tear and senescence. Damage to joints occurs with increasing frequency after the third decade.

No definite etiology has been established. Heredity, trauma and impaired circulation are probably factors.

Clinical laboratory studies are nonproductive. Roentgen findings are not satisfactory. In some active cases slight or no changes can be demonstrated roentgenographically; on the other hand, patients with extensive roentgen findings may be symptom-free.

The customary treatment of osteoarthritis is generally palliative with little expectation of prolonged relief.

Albedocone was administered orally to 141 unselected patients with good response in 108, fair response in 20 and failure in 13. The results were highly satisfactory when compared to those with other therapies. Some patients, especially younger ones and those who had minimal lesions, have remained symptom-free for one year after discontinuing Albedocone. Others who had recurrences again responded to Albedocone. A group of older women with extensive osteoarthritis and osteoporosis made exceptionally good responses considering their physical condition. There was also an improved sense of well-being.

Rheumatoid and gouty arthritis did not respond to Albedocone. Patients with extensive damage of large joints and also those with heavy psychosomatic overlay due to environment generally did poorly.

There was no evidence of toxicity or cumulative effects even after prolonged therapy. Instances of intolerance were usually of gastric origin. They were few and mild.

This study was made by 12 investigators in private practice except for 22 cases reported by University of Florida investigators. There was no selection of cases or correction of statistics.

Conclusions

Considering the fact that all patients with a diagnosis of osteoarthritis received treatment, the results have been excellent. Had there been some selection of cases with the ruling out of patients who had serious structural damage in the joints and patients who had obvious psychosomatic overlay, the results would have shown practically no failures and a lesser number classed as fair results. In other studies in which the effects of Albedocone could be observed objectively, it appeared to have a revitalizing effect on tissues that were involved in indolent inflammatory processes. It is suspected that there is a similar effect in osteoarthritic joints.

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Rheumatic Fever Below the Age of Five

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Rheumatic fever has long been considered an uncommon disease in Florida at all ages and in all races, and recent investigations of the prevalence of rheumatic heart disease among Florida school children appear to substantiate this clinical impression.[1-3] In addition, other studies of mortality data[4] and autopsy material[5] indicate that Florida-born persons are less likely to die from rheumatic heart disease than are immigrant Floridians. Since the over-all prevalence of rheumatic heart disease is comparatively low in Florida, one would expect cases of rheumatic fever and deaths from rheumatic heart disease in children below the age of five years to be exceedingly uncommon. Statistics from other areas indicate that over 90 per cent of all cases of rheumatic fever occur after the age of four years,[6] and that in a group of 2,324 patients only 8.4 per cent had their initial attack under the age of five years.[7]

Some investigators,[8] however, think that this disease is much more common below the age of five than is generally suspected, and tend to minimize the usefulness of rigid diagnostic criteria in this age group. Also, the recent introduction of effective surgical treatment for congenital heart disease and of diagnostic facilities for viral infections has served to augment the general tendency to attribute cardiovascular complaints in early life to causes other than rheumatic fever.

The influence of these conflicting views has probably increased the difficulty in diagnosing rheumatic fever in an area of low prevalence such as Florida. It also has increased many physicians' concern over prophylaxis for these young patients with questionable diagnoses.

Registered Cases

The following characteristics were found in a group of children below the age of five years reported to the Florida Rheumatic Fever Case Register as having had rheumatic fever or having died from acute rheumatic fever or rheumatic heart disease in Florida. The size of the group in no way indicates the incidence of the disease for this age although the five deaths reported on represent all patients below the age of five diagnosed as having died from rheumatic fever or its sequelae during a 21 month period.

A total of 20 cases of rheumatic fever in patients under the age of five years has been reported to the Register since its establishment in 1955. These represent 3.1 per cent of 645 cases in patients below the age of 30. Since the reporting procedure involves the contact of internists and general practitioners as well as pediatricians, no selection of patients in the youngest age group has been made. Table 1 shows that 12 of the 20 conformed to the modified Jones Criteria for the diagnosis of rheumatic fever. In spite of this conformity, however, the diagnosis in one case was subsequently proved to be in error. In five of the eight cases which did not meet the Jones Criteria, findings later developed which strongly implicated the initial attack as being rheumatic fever. Thus over one half of the group classified as not meeting the Jones Criteria have definite evidence to support a diag-

Table 1. — Florida Rheumatic Fever Cases Register: Ages of Twenty Rheumatic Patients at Time of Original Attack by Race, Diagnostic Criteria (Jones Modified) and Follow-up Data

Criteria	White	Negro
2 or more major	4,3* 3**	4, 4*
1 major and 2 or more minor	3,3,4* 2,4	3, 1
1 major	3	
2 or more minor	4, 4, 3*	
1 minor	4*	4*, 3*
No diagnostic data	3*	

*Had subsequent attack of rheumatic fever, or evidence of rheumatic heart disease developed.
**Diagnosis proved to he erroneous.

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Table 2. — Summary of All Deaths Below Age Five Reported as Rheumatic Carditis, June 1956 Through February 1958 in Florida

Gross autopsy diagnosis only (coroner's case)	1
Jones Criteria fulfilled clinically, but no autopsy evidence of rheumatic carditis	2
Jones Criteria fulfilled, no autopsy	1
No diagnostic data	1

nosis of rheumatic fever now. Repeated follow-up may reveal additional diagnostic data in the remainder also. These findings would tend to support the views of those investigators who think that the modified Jones Criteria should not be relied upon in cases occurring in children below the age of five since these criteria are not sensitive enough to pick up questionable cases.

During the period from June 1956 through February 1958, there were 785 deaths from rheumatic fever and rheumatic heart disease recorded with the Bureau of Vital Statistics of the Florida State Board of Health. Five deaths occurred in children below the age of five years with the respective ages being three years, one year, four years and nine months, two years, and 21 months. Follow-up data were obtained on all but the one which occurred in the child aged 21 months. The case in which the patient died at the age of three came from a medical examiner's office, and the diagnosis was based entirely on gross anatomic findings recorded as "rheumatic mitral valvulitis, myocardial hypertrophy and right ventricular hypertrohy." An "interstitial mononuclear pneumonia, liver tubercles, old cystic defects of the brain stem, atrophy of the anterior horns of the thoracic spinal cord and muscular atrophy of the right lower extremity" were also present, indicating the possibility of pathogenic processes other than those of rheumatic fever. The case in which the child died at the age of four years and nine months met all of the Jones Criteria for acute rheumatic fever, manifesting carditis, polyarthritis and subcutaneous nodules as well as four minor criteria. No autopsy was obtained in this case. The two remaining fatal cases fulfilled the Jones Criteria clinically, but at the time of autopsy no evidence of the rheumatic process could be demonstrated. The patient dying at the age of one year had an acute, diffuse interstitial myocarditis (Fiedler's) with acute interstitial pneumonia also. Similiar findings of a nonspecific interstitial myocarditis were present in the child who died at the age of two. Thus in none of the five cases in which the patient was reported to have died of rheumatic carditis was there both clinical and pathologic evidence of a rheumatic process (table 2).

Table 3. — Manifestation Used in the Diagnosis of Rheumatic Fever

Polyarthritis	Fever
Chorea	Arthralgia
Subcutaneous nodules	Increased sedimentation rate
Erythema marginatum	Prolonged P-R interval on electrocardiogram
Carditis	C-reactive protein positive
Murmurs:	Increased antistreptolysin
significant	O titer
apical systolic,	Preceding streptococcal infection
apical mid-diastolic, basal diastolic	Previous history of rheumatic fever or inactive rheumatic heart disease
Increasing enlargement	
Pericarditis	
Congestive failure	

*At least two major or one major with two or more minor criteria must be present.

The oldest child probably died of rheumatic fever since she had reached the "maturation"[9] which appears necessary before rheumatic sensitization occurs. This examination of deaths would appear to substantiate the beliefs of those investigators who think that rheumatic fever is "overdiagnosed" in the age group below five, especially in patients manifesting rapid cardiac decompensation and death. Even though rigid criteria were followed, in two cases out of five erroneous diagnoses were still made (table 3).

Summary

Although documented cases of rheumatic fever occur in children below the age of five in Florida, substantiation of the diagnosis is extremely difficult and can only be proved after long term follow-up.

The use of the modified Jones Criteria appears to offer little advantage in this age group since the items are not sensitive enough to pick up border line cases nor specific enough to prevent conflict with other syndromes.

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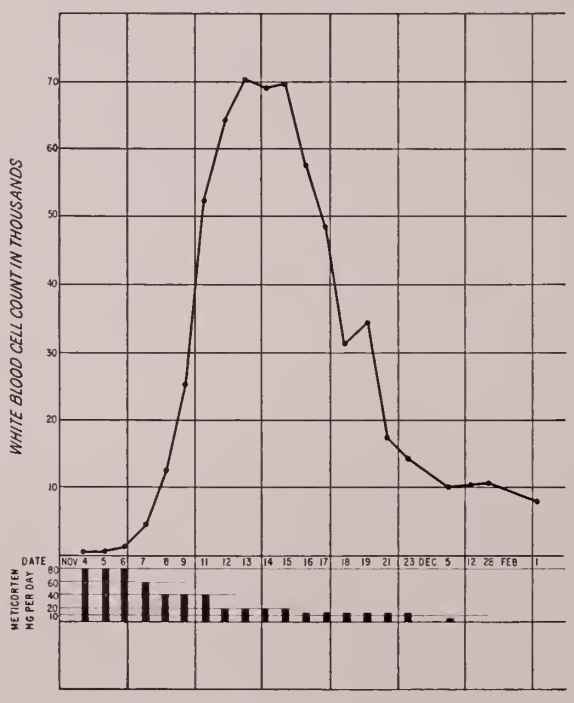
Severe Leukemoid Reaction After Promazine-Induced Agranulocytosis

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Since the use of chlorpromazine became widespread, there have been numerous articles[1-3] on the incidence of agranulocytosis occurring with the drug. Promazine (Sparine), which is chemically similar to chlorpromazine except that it lacks the chlorine atom, is of more recent origin, and there have been few case reports on its hemotoxic properties.[4] A case is therefore reported to alert the physician to the potential danger of this drug and to emphasize the necessity of frequent blood counts in using promazine or any chemically related compound, present or future.

Report of Case

A 59 year old white woman was given Sparine, beginning on Sept. 15, 1956. A dose of 150 mg. per day was maintained for five weeks, then 50 to 100 mg. per day. The only other medication taken at that time was an occasional 0.5 grain tablet of phenobarbital. On October 29, a sore throat and swelling of the cervical lymph glands developed. She was seen at home and given oral penicillin. After 36 hours with no improvement, she was given Ilotycin orally. In spite of this therapy the throat became progressively sorer and the cervical lymph nodes larger and very tender. She was therefore hospitalized. On admission to the hospital, the temperature was 99.6 F. and the pulse rate 98. The entire throat was greatly inflamed, but no ulcerations were visible. The anterior cervical lymph glands were enlarged bilaterally and were very tender. The remainder of the physical examination gave essentially normal results.



The initial blood count was 750 white blood cells with 100 per cent lymphocytes and 4.32 million red blood cells; the hemoglobin estimation was 12.7 Gm. Sternal marrow aspiration that day, performed by Dr. O. Whitmore Burtner, revealed moderately severe bone marrow depression with complete maturation arrest at the myelocyte stage. It was decided that the patient should be given high doses of Meticorten (80 mg. per day initially), procaine penicillin 600,000 units daily, and Sigmamycin 500 mg. every six hours. Chloral hydrate was used for sedation. She showed excellent response to therapy. The temperature was normal in three days and remained

Table 1. — Hematologic Response

1956	Total White Blood Cell Count	Per Cent Granulocytes
Nov. 4	750	0
Nov. 5	950	1
Nov. 6	1,250	7
Nov. 7	5,450	49
Nov. 8	13,300	65
Nov. 9	25,650	88
Nov. 11	52,600	86
Nov. 12	64,500	72
Nov. 13	70,400	80
Nov. 14	69,000	89
Nov. 15	69,600	86
Nov. 16	57,600	94
Nov. 17	48,900	86
Nov. 18	31,600	81
Nov. 19	34,400	90
Nov. 21	17,700	73
Nov. 23	17,100	69
Dec. 5	10,200	70
Dec. 28	10,500	68
1957		
Feb. 11	8,000	70

so. The hematologic response was most unusual. The total white blood cell count was as high as 70,000 (table 1). The red blood cell and platelet counts and the hemoglobin estimation remained normal throughout. Although a highly nervous person, the patient tolerated the high dose of Meticorten extremely well. The Meticorten was gradually reduced over a period of five weeks and then discontinued. Antibiotics were discontinued 10 days after the start of therapy. The patient has remained well, and her blood count has remained normal.

Summary

A case of agranulocytosis in a patient taking Sparine for two months is reported. Of special interest is the severe leukemoid reaction occurring in the recovery period.

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ABSTRACTS

Anomalous Case of Edema, Anasarca, and Polyserositis. By Leonard G. Rowntree, M.D., William J. Winter, M.D., Harvey E. Brown Jr., M.D., and Robert J. Boucek, M.D. J. A. M. A. 168:411-413 (Sept. 27) 1958.

A case of anomalous edema is reported which was characterized by a slowly progressive downward course ending in anasarca, polyserositis, and death. The diagnosis in life was indeterminate despite several months spent in the hospital and innumerable laboratory tests. Clinical studies and autopsy examination excluded all the commonly recognized diseases associated with edema, such as diseases of the heart, liver, kidneys, and blood, and also the more unusual syndromes. It was concluded that this case may represent a new syndrome similar in part to three others previously reported by Dr. Rowntree, representing a disease that is the antithesis of diabetes insipidus, characterized by salt and water retention and postulated as possibly due to "hyperpitressinism." Marked histologic changes which may possibly be of pathogenic significance were encountered in the cells of the supraoptic nuclei.

Followup of Blastomycin Sensitivity in an Epidemic Area. By J. Graham Smith, Jr., M.D., Walter C. Humbert, M.D., and Sidney Olansky, M.D. Pub. Health Rep. 73:610-614 (July) 1958.

To examine further the reactivity of healthy persons in a blastomycosis epidemic area to the blastomycin and histoplasmin skin tests, a second survey was conducted in the area of Grifton in Pitt County, N. C., in May 1956. It included 43 of the 83 persons who had had positive blastomycin skin tests or positive blastomycosis complement fixation tests in a survey in April 1954. In the two year period, 34.8 per cent of the previously positive blastomycin skin test reactors had reverted to negative, and 91 per cent with previously positive complement fixation to blastomycosis were now negative. No conversions to positive blastomycin skin tests were found in the selected group included in this survey, but two persons previously negative to the blastomycosis complement fixation test were found to be positive. Both skin sensitivity to blastomycin and blastomycosis complement-fixing antibodies tended to decrease in the two year period, but the complement-fixing antibodies disappeared in a higher percentage of the persons tested. Seven persons became reactive to the histoplasmin skin test and three lost their reactivity. None of the group surveyed had a positive histoplasmosis complement fixation test.

Nonsurgical Chronic Otorrhea; Causes of Therapeutic Failures and a Review of Advocated Remedies. By A. R. Hollender, M.D., F. A. C. S. Eye, Ear, Nose & Throat Monthly 37:515-520 (Aug.) 1958.

The author warns that decision to resort to surgical intervention for chronic suppuration of the ear is sometimes made too hastily and without complete justification. Under some circumstances, especially in uncomplicated aural suppuration, he advocates giving nonsurgical treatment a thorough trial. Although the cause remains obscure as a rule, there are definite factors

which influence the persistence of aural discharge, and the role of the air cell system of the mastoid bone, as described by Diamant, merits consideration. Basic therapeutic considerations include essentially indicated operations in areas related to or associated with the aural suppurative process. Causes of failure of nonsurgical therapeutic measures include mainly lack of a methodical therapeutic plan, inability to support the selection of the remedial agent employed with bacteriologic studies of the discharge, and shoddy therapeutic technic. Advocated topical methods include the wet and the dry treatment, the majority of clinicians leaning to the latter. Aural suppuration is occasionally influenced by diseases of other organs and systems, and a comprehensive effective plan of management must embrace adequate correction of these underlying ailments.

Meningioma of the Optic Nerve OF ONE MONTH'S CLINICAL DURATION. By Thomas S. Edwards, M.D., and John R. Finlay, M.D. Am. J. Ophth. 46:745-747 (Nov.) 1958.

Meningiomas of the optic nerve are relatively rare and usually characterized by slow growth. It is the purpose of this paper to report a primary meningioma of this nerve of one month's clinical duration. In this case the patient's vision decreased in a period of two weeks from 20/100 to hand motions. Although proptosis and limitation of ocular movements are frequent signs of tumor of the optic nerve, neither was present as late as the day before enucleation. The gross and microscopic pathology is discussed, and it is concluded that the lesion was an intraorbital tumor arising in the optic nerve.

The Composition of Private Pediatric Practice in a Small Community in the South of the United States. A TWENTY-FIVE YEAR SURVEY. By J. R. Boulware, M.D. Pediatrics 22:548-558 (Sept.) 1958.

A summary of the preventive treatments given and the different types of diseases and conditions encountered in 25 years of private pediatric practice in a small Southern community is presented. The practice described may be considered representative of the practice of pediatrics in central Florida; the patient material is drawn from a city with a population of 18,000 in 1931 now grown to 40,000, and from the surrounding smaller towns. There are 19 classifications in the summary, and an estimate of the percentage of time devoted to each classification is tabulated. Preventive medicine, that is, routine care of infants, preventive treatments and routine examinations, constituted about two fifths of this pediatric practice.

Granting that firm scientific conclusions cannot be drawn from this study, the author is nevertheless of the opinion, based on records resulting from a quarter of a century of practice, that an awareness of a disease in the mind of the pediatrician influences his diagnosis, that the locale of a practice will make for differences in incidence of certain diseases, and that the pattern of diagnosis, as well as of diseases, changes.

The Development of a Successful Technic for Cataract Extraction. By Curtis D. Benton, Jr., M.D. South. M. J. 51:1562-1566 (Dec.) 1958.

The purpose of this article is to show how the search for a completely successful technic for cataract extraction has progressed and is progressing for one "occasional operator," as the author classifies himself, and how various complications have been reduced by the adoption of important ideas proposed by more experienced surgeons. He reports the technics and results of 180 consecutive cases of intracapsular or attempted intracapsular cataract extractions and describes how his technic has changed in recent years to enable him to adapt various improvements to the operation. Some changes have been tried and discarded, but others have been found valuable and retained. The technic employed at present is based on the premise that the least manipulation gives the best results provided there is proper emphasis on secure wound closure. Operative and postoperative complications of all types including capsule rupture occurred in 32 per cent of the cases, but in only 6.1 per cent were they responsible for any visual impairment. As the technic has been improved, the incidence of complications has gradually lessened.

Eighty-nine per cent of the 180 patients obtained a visual acuity of 20/30 or better in the operated eye. The necessity of continual improvement in operative technic is stressed.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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RALPH WILLIS JACK, M.D.
President 1959-1960
Florida Medical Association

Ralph Willis Jack, M.D., President

The incoming President of the Florida Medical Association, Dr. Ralph Willis Jack of Miami, has spent his entire professional career in that city, having entered the private practice of medicine there 23 years ago. His specialty is obstetrics and gynecology.

On May 6, 1903, Dr. Jack was born in Omaha, Neb., and on May 6, 1959, exactly 56 years later, he acceded to the Association's highest office. He attended Yale University, where he was awarded the Bachelor of Science degree in 1926. For his medical training he entered the Johns Hopkins University School of Medicine and in 1930 received the degree of Doctor of Medicine from that institution. An internship at the Johns Hopkins Hospital from 1930 to 1932 was followed by residencies there in obstetrics and gynecology and in pathology from 1932 to 1936. During 1929, there was also a period of special study in Scotland at Edinburgh University.

In 1936, Dr. Jack located in Miami, where he has since had a prominent role in the medical, civic and social life of that city. He is a senior attending surgeon on the obstetrics and gynecology service of Jackson Memorial Hospital and attending physician at Victoria Hospital in Miami and also consultant at St. Francis Hospital and Mount Sinai Hospital of Greater Miami in Miami Beach. He was a member of the original medical advisory committee to the University of Miami School of Medicine. A member of the board of directors of the Cancer Institute at Miami and of the John Elliott Blood Bank of Dade County, he has also been an associate member of the board of directors of the Dade County Chamber of Commerce.

Active in official circles of the Dade County Medical Association, Dr. Jack became chairman of the committee on cancer control in 1950 and of the board of censors two years later. In 1953 he was elevated to the presidency of that organization and in 1955 became chairman of the board of trustees.

The Association has been fortunate to have the benefit of Dr. Jack's services in various official capacities in recent years. In 1942 Dr. Jack received a four year appointment to the Committee on Maternal Welfare, but entered military service before the term was completed. Since 1954 he has been chairman of the Credentials Committee. In 1955 he served as chairman of the Council, held the office of First Vice President two years later and in 1958 became President-Elect. At the state level he also served as a member of the Governor's Committee on Hospitalization of the Indigent. He has been a member of the Medical Advisory Committee to the State Board of Public Welfare since that committee was established.

Prominently identified with outstanding national medical organizations, Dr. Jack was chairman of the program committee of the 1954 Clinical Session of the American Medical Association. He served the Continental Gynecologic Society as vice president in 1953 and as president in 1958. From 1955 to 1958 he was state vice regent of the International College of Surgeons, and in the American College of Obstetricians and Gynecologists he filled the post of section vice chairman from 1953 to 1956, was elected district vice chairman in 1958 for a three year term, and in April 1959 was elected second vice president. He is also affiliated with the Southern Medical Association, the American College of Surgeons, the Southeastern Surgical Congress, the South Atlantic Association of Obstetricians and Gynecologists, the Association of Military Surgeons of the United States, and the Pan Pacific Surgical Society.

During World War II, Dr. Jack served with distinction from 1942 through 1945 in the Medical Corps of the United States Navy with the rank of commander. For his service as amphibious combat surgeon at Iwo Jima he received a Navy Unit Citation and also received a second Citation of the same award for service at Okinawa.

Dr. Jack is a member of the Phi Gamma Delta fraternity. He holds membership in the Miami Club, the Committee of One Hundred of Miami Beach, the Torch Honor Society of Yale University, and the Pithotomy Club of the Johns Hopkins University.

Dr. Jack and Mrs. Jack, the former Miss Ruth Garland of Farmville, Va., reside in Miami Beach. They have one daughter, Mrs. Joan Jack Sprague, and one son, William David Jack II.

PRESIDENT'S PAGE

Up to Date

If you attended the annual convention in Bal Harbour last month, you undoubtedly had a good time socially, and I know you were enlightened by an excellent scientific program. If you attended the business sessions of the eighty-fifth annual meeting of the House of Delegates, you learned that your officers and committees have been extremely busy during the past year and for several years previous to that. There has been a big job presented to us—all of us.

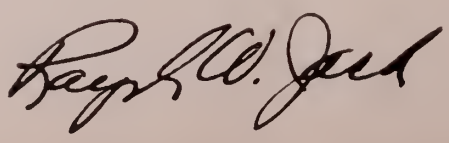
The proposed new Charter and By-Laws of the Florida Medical Association is the first major change suggested in our Constitution and By-Laws for many years. The gradual and the more rapid changes in our way of life over these years, the great growth in the population of our state and the consequent large increase in our own number, the many advances in all phases of medical science, the changes in our laws, public health policies, public opinion and social structure have dictated a need for the Florida Medical Association to get up-to-date.

These happenings which have called for a change in the organization and in some of the policies of our Association took years to develop. Likewise, the proposed Charter and By-Laws did not come about overnight. It has required many hours of thoughtful consideration and research on the part of those charged with putting these changes into words. Hours that grew into days and days that grew into weeks; time given by devoted members of this Association for your benefit, the benefit of the public we serve, now and for a great many more years to come. All changes proposed have been made to help us better accomplish our objects and purposes in the changing world in which we now operate. There has been no change in our purposes except to streamline the phraseology so that it fits in an atomic and jet-propelled age. Allow me to quote the Purposes of the Association, Article II of the Proposed Charter.

The purposes of this Association are "to unite the medical profession of Florida into one compact organization and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical education; to strive for the enactment, preservation and enforcement of just medical and public health laws; to promote friendly relations among physicians and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies. . . ."

We must be ever mindful of these purposes and see that we are capable of carrying them out. To do so requires the adoption of the new Charter and By-Laws. These must be ratified by our component county societies. I urge all of you to aid your individual county society in taking this positive action at an early date. Your officers and committees need your assistance in bringing about this important reorganization. Give us your advice and your criticisms, but also give us your support by giving us this important "tool chest" for carrying out the purposes, the work and the business of the Association.

Your officers have pledged to you in all sincerity the best of their ability. Help them to make the 1959-1960 year a year of full accomplishment by an early ratification of the Charter and By-Laws. It was Thucydides who said the Greeks possessed "the power of thinking before they acted, and of acting, too." I believe the same is true in a high degree of the Florida Medical Association. Let us follow the thought of Sir William Osler, "To know just what has to be done, then to do it, comprises the whole philosophy of practical life."



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A Meeting of Minds in Overlapping Professions
Physicians and Clergy Counsel Together

"I'm going to play golf tomorrow for the first time since Lent began and I can hardly wait," remarked a vigorous young medical colleague last Easter morning as he sat down beside me at the counter in the hospital coffee shop and ordered a sandwich.

"Do you give up something important to you each year for Lent?" I asked.

"Yes, it is really spiritual things that matter—that make one truly happy," he replied and then, unembarrassed and articulate, he began to talk. As I reflected upon the content of his thought, I seemed to know that he was sincere and not attempting to be dramatic or show-offish.

Immediately, I began to wonder how many physicians use a spiritual approach to their problems. What percentage of vigorous, well rounded, successful young medical practitioners today pause to probe deeply? I took time to tell my youthful colleague one of my favorite stories:

A grieving and bewildered young widow brought a six year old son to her hero and friend, aging General Robert E. Lee, soon after the War Between the States, for a word of advice on rearing him. "Madam," said General Lee, "teach him to deny himself."

As I left the coffee shop, my mind turned back to a conference held in Jacksonville in December 1958. Bishop Hamilton West of The Protestant Episcopal Church, Diocese of Florida, invited Florida physicians who were Episcopalians and members of the Florida Medical Association to devote a week-end to a work conference which had to be taken as a whole, not sampled.

The Reverend A. T. Mollegen, Professor of Apologetics and Christian Ethics at the Virginia Theological Seminary in Alexandria, Va., the leader of the conference, was an immediate success. Displaying knowledge of wide range and scope, he began by giving the doctors a sample of his deep understanding of fundamental problems encountered by the ethical physician in the practice of medicine. Here was the teacher striking a spark from his students. Here was the professor, unimpressed with himself, a lover of truth who asked nothing more than to come to grips with the issues at hand.

Meeting minds with "Molle" was a challenging and inspiring experience. Content to give rapt attention for three hours the first night and 10 to 12 hours the next day, the group of some 25 physicians met in final session on Sunday morning and voted to have a similar conference within a year with no important changes in method or scope and of course no change in leadership. This group of mature physicians, unusually attentive and deeply interested throughout, could hardly have responded otherwise in view of the outstanding ability of the leader and the excellent planning of Bishop West. Here was a pattern to follow.

Association Past President Honored For Half Century of Service to Medicine

Dr. Julius C. Davis of Quincy was honored by his friends and patients at a reception in the Quincy National Guard Armory on April 30 at 4:30 p.m. in recognition of his completion of 50 years of medical practice. Hundreds of his friends and patients were on hand to pay tribute to this distinguished practitioner. A great many of his colleagues from North Florida and South Georgia were also present to add their congratulations.

Dr. Davis Day was proclaimed by action of the Quincy City Commission, and Dr. Davis was presented with the original copy of the proclamation by Mayor-Commissioner H. V. Fletcher.

A PROCLAMATION

By the Mayor-Commissioner of
The City of Quincy

Whereas Julius C. Davis, M.D., F.A.C.S., F.I.C.S., will have completed a half-century of medical and surgical practice on the thirtieth day of April next, forty-eight years of which have been in Quincy and Gadsden County, Florida; and

Whereas he has ever carried his full share, and often more, in the civic and professional enterprises undertaken for the general welfare of this community, in particular including the promotion and establishment of hospital facilities for the people of Quincy and Gadsden County;

Now, therefore, I, H. V. Fletcher, Mayor-Commissioner of the City of Quincy, Florida, by the unanimous consent of the City Commission, do issue this my proclamation, appointing Thursday the thirtieth day of April next as DOCTOR DAVIS DAY, and I do earnestly request all the good citizens of this city and county to observe the same in appreciation of the high quality of his long and faithful services to mankind and in a spirit of affectionate regard for him as a fellow citizen.

Given under my hand and the seal of the City of Quincy, this thirteenth day of April, in the year of Our Lord one thousand nine hundred and fifty-nine.

H. V. Fletcher

By the Mayor-Commissioner:
James F. Cross,
Clerk of the City Commission of
the City of Quincy, Florida.

He was also presented with a photograph of a plaque to be placed in the Gadsden County Hospital in his honor, and with a copy of a resolution adopted by the Board of County Commissioners of Gadsden County. This resolution was presented by Commissioner E. P. Woodward.

Whereas, on the 30th day of April, 1959, Julius C. Davis, M.D., F.A.C.S., F.I.C.S., will have completed fifty years of medical and surgical practice, forty-eight years of which have been in Quincy, Gadsden County, Florida, and

Whereas, he has wholeheartedly devoted this half century to the skillful and compassionate healing of the sick, the repair of broken bodies and the furtherance of the health and well-being of the people; now therefore,

BE IT RESOLVED BY THE COUNTY COMMISSIONERS OF GADSDEN COUNTY, FLORIDA:

1. That by this official resolution we desire to commemorate and honor his fifty years of service and to publicly acknowledge and proclaim the community's indebtedness to him for his services.

2. That this resolution be inscribed upon our records as a permanent memorial in honor of his distinctive and faithful services to mankind.

H. B. Hirt, Chairman
Board of County Commissioners
Gadsden County, Florida

ATTEST:
Edwin Baur, Clerk

Dr. Davis was presented a plaque commending his dedicated service to organized medicine by Dr. Hilliard R. Reddick, President of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. In presenting the plaque, Dr. Reddick called attention to the fact that Dr. Davis had helped organize this medical society in 1919 and had contributed as much to organized medicine in general as any individual in the state of Florida, a very important fact, since the progress of medicine has so closely paralleled the organization of medicine. What is definitely more important is the almost unbelievable amount of good this man has accomplished during these 50 years as a practitioner of the art of medicine in Gadsden County. This good will reflect itself again and again as generations pass.

As a part of the program, short speeches as tokens of respect were made by Dr. Taylor W.



Dr. Julius C. Davis greets Mr. Abner Averitt who was the first baby he delivered after beginning his practice and the daughter of Mr. Averitt, one of the last babies delivered by Dr. Davis.

Griffin, of Quincy, President of Gadsden County Hospital Medical Staff, by Dr. Fred A. Butler, of Tallahassee, by the Reverend Dr. R. C. Holmes of Lakeland, by S. C. Crouch, a pharmacist in Quincy for over 50 years, and by Abner Averitt Jr., the first baby delivered by Dr. Davis. In addition, several recorded messages from Dr. Jere W. Annis of Lakeland, Dr. Samuel M. Day and Dr. Wilson T. Sowder of Jacksonville, Dr. Walter C. Jones of Miami and many other friends in the medical profession unable to attend were presented to Dr. Davis.

In the receiving line with Dr. Davis were his wife, his two sons, L. P. Davis of Orlando and Dr. Julian C. Davis of Chattahoochee, and their wives, and his daughter, Miss Lora Frances Davis of Houston, Texas, as well as his only living brother, J. Wiley Davis of San Juan, P. R.

Among the out-of-town guests representing the medical profession were Dr. and Mrs. Francis M. Watson and Dr. and Mrs. Courtland D. Whitaker of Marianna; Dr. and Mrs. Francis T. Holland, Dr. and Mrs. Robert N. Webster, Dr. and Mrs. G. Wilmot Brown Jr., Dr. and Mrs. Laurie L. Dozier and Dr. Nelson H. Kraeft, all of Tallahassee; Dr. Gordon Chason of Bainbridge, Ga., and Dr. William H. McCullagh of Jacksonville.

As part of the program a resume of Dr. Davis' life was used, which follows:

Julius C. Davis Jr., was born June 27, 1886 on a farm near Waynesville, N. C. The son of Zachary Clingman and Lora Jane Noland Davis, he was the eldest of five sons, the brothers being Hamilton Ewart, J Wiley, Hobart and Clinton. The only one living now is J. Wiley Davis, Chief Alcohol Tax Unit, Puerto Rico and the Virgin Islands (San Juan, P. R.). On Jan. 30, 1911, Dr. Davis was married to Bonnie Jean Marquardt in Atlanta, Ga. The children were twins, Julius C. Jr., who died at the age of five months, and L. P. of Orlando, Julian Carlyle of Chattahoochee, and Lora Frances of Houston, Texas.

EDUCATION.—Dr. Davis attended high school in Clyde, N. C. and went one year, 1903, to Carson Newman Business College, Jefferson City, Tenn., and one year, 1905-06, to Davidson College, Davidson, N. C. He was graduated from the Atlanta School of Medicine (now incorporated into Emory University) on April 26, 1909, and had the highest grades in his class.

Before graduation he had a mild bout with tuberculosis in 1907. Between his junior and senior years, in the summer, he had done a "bush-whacking" practice, as he called it, at Topton, N. C.

LICENSING.—The day after graduation he took the Georgia Board and passed with a grade of 92. In school he had been the "quiz master" for his class and had held sessions for his classmates. Dr. C. L. Hyatt from Kathleen, Fla. persuaded him to go back with him and continue the coaching until the Florida Board. He made 93 on the Florida Board. Then he went up to North Carolina and made 88 on that board.

FIRST LOCATION.—A young doctor in Candler, N. C. had just died, and his uncle, Dr. F. M. Davis of Canton, urged him to enter practice at Candler in June 1909. While Dr. Davis was at Candler, nine miles from Asheville, he assisted Dr. Frank T. Meriwether at the Meriwether Hospital in surgery and Dr. E. B. Gleen at the Biltmore Hospital and was on the courtesy staff of the Mission Hospital, all of Asheville. He practiced there two

June Cover



Hippocrates
Medicine Becomes a Science

Kindliness, concern, and love for the art of healing are reflected in the face of Hippocrates as he palpates a young patient. Revered practitioner, scientist and teacher, this great Greek physician of the fifth century B. C. well deserved the title, "Father of Medicine," which has been associated with his name for over two thousand years.

(Courtesy of Parke, Davis & Company)

years, but the cold winters, the long hours of horseback riding up the mountains, a heavy pneumonia epidemic, and a fall and broken ankle when his horse fell, made him turn his thoughts to a warmer climate.

QUINCY.—In May 1911, Dr. Davis sold his office equipment to Dr. J. C. Rich in Candler and, responding to Dr. Francis Phillips' ad in the Journal of the American Medical Association, bought his practice and office equipment in Quincy for $750. He has been in Quincy since that time.

PROFESSIONAL ACTIVITIES.—Always a great believer in organized medicine, in 1913 he helped to organize the Leon-Gadsden County Medical Society, the first meeting being held in Tallahassee and the second in his office in Quincy. Later, this society was reorganized into the Second District Medical Society in 1920, and he was president that year.

For a number of years he was chairman of the Legislative and Public Policy Committee of the Florida Medical Association, and it was this committee which was responsible for the Florida basic science law. He was elected to the three highest offices in that association: Second Vice-President, 1913-1914; Third Vice-President, 1923-1924; and President, 1929-1930. He was named President just after he spent four months in bed and always felt somewhat abashed that he was not able to travel, visit as many local societies and attend as many other functions as he would like to have done that year. In 1932 he was named President of the Chattahoochee Valley Medical and Surgical Association, a society composed of Florida, Georgia, and Alabama members.

Dr. Davis is a member of the Southern Medical Association. A charter member and one of the founders of the Southeastern Surgical Congress, he was First Vice President in 1957 and for years served as counselor, resigning in 1957. For over 25 years he has been a surgeon for the Seaboard Airline Rail Road Company, and in 1955 he was President of the Florida Railway and Industrial Surgeons. He is a fellow of the American College of Surgeons and has served on the Florida Credentials Committee for about 30 years. In 1957 he was elected President of the Florida Chapter of the American College of Surgeons and served during 1958. From 1939 to 1955 he served as one of the State Regents for the International College of Surgeons.

In 1913 he took a six week course of x-ray instructions from Dr. John S. Derr, one of the first doctors to limit his work to radiology. Dr Davis then installed the first x-ray unit in this section of the state. Dr. Derr returned to his native Virginia, where he recently died.

Perhaps more than any organization or formal activity, he remembers best and gained most from a trip made in 1916. He had gone to Atlanta to have an appendectomy. Afterwards, his good friend and teacher, Dr. E. C. Davis, and some other distinguished physicians were leaving on a trip together to some of the leading clinics in America. Dr. E. C. Davis' roommate for the trip could not go, and he urged the younger Dr. Davis to join him. They saw many of the great men of that time at work, visited with them and were entertained by them—Doctors Crile, Kellogg and the Mayo Clinic staff. He went back to the Mayo Clinic for study and observation of the work there a number of times. On the return trip, Mr. D. A. Shaw had arranged to have a new Ford delivered to him in Atlanta. It had an automatic starter and was the first in Quincy. Ever afterwards he loved automobiles. He stopped by Fort Benning, took the physical examination and was commissioned a First Lieutenant in the Army Medical Reserve Corps. His commission was signed by Woodrow Wilson. During World War I he was Surgeon for the local draft board and would have been on the last shipload of doctors to France except for having a severe attack of influenza. During the epidemic he had worked at the draft board during hours, and then into the night attending the sick. He was so ill himself that his death was reported in several papers. After the armistice he resigned. During World War II he was Chairman of the Medical Advisory Committee for the state.

With the advent of pensions for veterans during the depression, 1928-1934, he became medical examiner for the Veterans Administration and to the present he serves as physician to the U. S. Veterans Administration under orders from the Bay Pines Facility. For several years, 1936-1940, he was medical referee for the Florida In-



Dr. and Mrs. Julius C. Davis (right) receive guests in company with Mr. J. Wiley Davis, a brother; Dr Julian C. Davis, a son, and Mrs. Davis; Miss Lora Frances Davis, a daughter; Mrs. Elizabeth Davis, a sister-in-law; Mr. L. P. Davis, a son, and Mrs. Davis. The child is the daughter of Dr. and Mrs. Julian C. Davis.

dustrial Commission, and in 1938 was appointed by the Governor as Chairman of the Merit System Board.

For a number of years, 1935-1949, he was a member of the Florida State Board of Medical Examiners and served as its President in 1938-1939. He resigned from the Board in 1949.

In 1936 he served as President of the Emory University Medical Alumni Associations, and that was the year of his first heart attack. He served as President of the Florida Medical Alumni in 1938.

Over the years many activities for promoting education, medical practice and surgery interested him, but he had three consuming interests to which he devoted much time and enthusiasm: (1) the Gadsden County Hospital (2) public health in Florida and (3) the Florida State Hospital. In 1919 he and Mr. I. Gardner asked Mr. Y. L. Watson to draw up a contract for the establishment of a stockholder's corporation for a county hospital. When this was done, he and Mr. Gardner began to sell stock and they began first with Mr. A. L. Wilson, who then joined them in this endeavor. When the hospital was organized, Dr. Davis gave his time and enthusiastically served as its elected Business Manager and Medical Director from 1920 to 1923. During this interim he acquired more stock as patients who could not afford to own it sold it to him. In this manner he came to own about 40 per cent of the stock. When the federal government made matching funds available to county-owned institutions, he gave his stock to the county in order for it to benefit by this matching fund and build a new hospital. One of the operating rooms thus bears his name in recognition of the gift of his share in the old hospital he helped to found. For many years he served the Florida State Hospital in various advisory capacities, and for some time was Clinical Director of Surgery, going over one afternoon a week, or oftener if needed, to perform major surgery. He resigned this position when he reached the age limit required by the state.

Believing strongly in public health, Dr. Davis in consequence had many house guests from the state and national health services, especially during legislative sessions. He actively worked to promote public health in Florida and to get a health unit in Gadsden County. He invited the State Health Officer, Dr. W. A. McPhaul, to speak at the Rotary Club and churches ahead of, and in preparation for, presenting Dr. McPhaul to the County Commissioners to request the county's cooperation in organizing a Gadsden-Liberty County Health Department.

For a time he was a visiting surgeon for the Florida A. & M. College Hospital and would take Negro patients there for surgery. He also would speak in their churches from time to time on health problems.

From the time of the planning in 1953 of the College of Medicine of the University of Florida and the J. Hillis Miller Health Center, he has served as an advisor to the University, and is still serving as advisor to the College of Medicine.

Dr. Davis enjoyed serving as a consultant in various hospitals: Jacksonville, Vero Beach, Marianna, Live Oak, Madison, Tallahassee, Monticello, Altha, and Blountstown in Florida. He has operated in a hospital in Marianna, the four Tallahassee hospitals, and two hospitals in Bainbridge, Ga. He was called in consultation to Orlando, and twice to Atlanta as surgical consultant.

The most significant of his articles was published in 1911, and again in 1920, on intravenous use of acriflavine injections for septicemia. That was before the days intravenous chemotherapy was used to combat many infections as it is today, and this paper predicted just such use of chemotherapy. He was one of the first to make use of this medium. In 1920 he also wrote an article on the early recognition of cancer of the lung and a report of cases in the early stages.

SOCIAL ACTIVITIES.—As a younger man he was more active in social and civic activities. He was a member of the Rotary Club, once being president, and is now an honorary life member. He was a member of the Elks Club and the Quincy Golf Club, which later combined with the Sawano Country Club, of which he was a charter member. He is a Mason, once having been Grand Worshipful Master, and once Eminent Commander of the Knight's Templar. Hunting was his favorite sport, and he used to keep fine bird dogs. When going on a call in the country, he would sometimes take his dog and his gun along.

Important Role of the Association's Medical Advisory Committee to Department of Public Safety

During the latter part of 1952 Col. H. N. Kirkman, Director of the Department of Public Safety of the State of Florida, and Capt. C. W. Keith, Head of the Licensing Division of the Department of Public Safety, contacted Dr. Francis T. Holland, of Tallahassee, in regard to problems they were having with certain applicants for a Florida driver's license because of their physical or mental disabilities.

Colonel Kirkman and Captain Keith stated that the laws of Florida gave them broad discretionary powers with regard to issuing licenses. When they denied a person the privilege of driving, however, they wished their decision to be on a sound medical basis and they needed advice and assistance in this matter. The problem was presented to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, and the society appointed a committee to assist the Department in screening these drivers. After several meetings, the committee realized that its duties should not be the function of a county medical society committee but of a committee of the Florida Medical Association. A resolution requesting the establishment of such a committee was presented by this society to the Association's 1956 House of Delegates and approved. Since February 1957 the Association's Medical Advisory Committee to the Department of Public Safety of the State of Florida has been active.

One might wonder why the Florida Medical Association should be interested in the physical examination of drivers. When one realizes that accidents are the leading cause of death of all

persons up through age 34 and second only to heart disease through age 44, and automobile accidents account for approximately 40 per cent of these deaths, and when one realizes that between 80 and 90 per cent of automobile accidents are due to the driver, the reason becomes apparent.

Since the Committee has been formed, it has gone forward studying how to get the most information concerning the patient with the least effort to both the patient and the family physician who examines these applicants. Each year the number has increased from 152 in the latter part of 1952 to well over 1,000 in 1958. As a result of the Committee's work, many hundreds have been eliminated from the highways. How many lives have been saved? Who knows? One may rest assured that many people in Florida have the utmost respect for the words that have appeared in thousands of letters, "the Medical Advisory Committee recommends." All reports to the Department of Public Safety are confidential, and the only way the Department will produce them is through a court order. The Department will not give out the names of the members of the Medical Advisory Committee to the public because of the political pressure that an applicant might put upon them and the general annoyance.

The National Safety Council has suggested that the American Medical Association request each of its component state societies to establish an advisory committee to the department in the individual states responsible for traffic safety. Florida was ahead of many of the other states in this respect as since early 1957 it has had such a committee at the state level rendering excellent service.

Referral Procedure at University of Florida Teaching Hospital and Clinics

The telephone number of the University of Florida's Teaching Hospital and Clinics has been changed. Officials of the Teaching Hospital and Clinics relate that some stationery still bears the old phone number and that some physicians have reported difficulty in reaching the institution by phone to make referrals.

The new phone number is FRANKLIN 2-3411 in Gainesville. Health Center stationery will reflect this new phone number as soon as present supplies are exhausted.

Physicians phoning the Teaching Hospital to make referrals for admission of a patient will be routed by the Health Center switchboard operator to a staff physician on the appropriate service. Nonemergency referrals may be made by mail, addressed to the appropriate medical service. A letter should follow all telephoned referrals, or it can accompany the patient.

Immediate outpatient appointments for the Clinics can be scheduled by the Central Appointments Office, although referral calls and mail should be channeled through a staff physician on the appropriate service.

Association's State Science Fair Awards Presented

Before an overflow crowd of junior and senior high school science students assembled April 11 in Florida State University's Opperman Music Hall, President Jere W. Annis of the Florida Medical Association formally presented the Association's third annual State Science Fair Awards for Medical Aptitude. The awards are offered to encourage promising students to undertake careers in various branches of medicine.

The winner of the First Award, Senior Division, was George D. Bittner, of Robert E. Lee High School, Jacksonville. He received a special



George D. Bittner of Robert E. Lee High School in Jacksonville receives first award, Senior Division, Florida Medical Association awards for medical aptitude, from Dr. Jere W. Annis, President, at the 1959 State Science Fair held April 9-11 at Florida State University, Tallahassee.



Manuel L. Cepeda of Ocala Junior High School in Ocala receives first award, Junior Division, Florida Medical Association awards for medical aptitude, from Dr. Jere W. Annis, President, at the 1959 State Science Fair held April 9-11 at Florida State University, Tallahassee.

hand-lettered citation and $75 in cash for his exhibit, entitled "Diagnostic Indications of Allergies Through Electrophoresis."

The First Award, Junior Division, was presented to Manuel L. Cepeda, of Ocala Junior High School, Ocala, for his exhibit "Experiment with Alcoholic Beverages." Young Cepeda, who received a special citation and $50 in cash, won the same award in last year's State Science Fair with a different exhibit.

The Woman's Auxiliary to the Association for the second successive year made available four honorable mention awards, each of which consisted of special hand-lettered citations and $25 in cash. These awards, which also were presented by Dr. Annis, were won by Jay J. Pfeiffer, Cocoa High School, "Cigarette Tars—Cancer?"; Marian A. Somers, Melbourne High School, "Genetics of Tumor Transplantation;" Kenneth L. Glasser, Coral Gables Senior High School, "Respiratory Quotient," and Edward H. Rice, Lakeland High School, "Comparative Anatomy—Vertebrates."

Of some 300 exhibits representing the winners in various categories of the state's regional and local science fairs, the Association's judging committee picked 51 exhibits to be judged for medical aptitude. From this number the final winners were selected. Each of the students whose exhibits were judged for the Association's awards was presented a certificate of recognition which was displayed at his exhibit during the two and one-half day science fair. The names of the winners were not announced until the awards ceremony was held on the final day.

The Association's judging committee, which was appointed prior to the State Science Fair by President Annis, consisted of Drs. Fred A. Butler, chairman, James K. Conn, Clarence W. Ketchum, and David J. McCulloch, all of Tallahassee, and William L. Hunter, of Monticello.

Committee on Medical Testimony Established

The announcement that the Florida Medical Association now has a new standing committee known as the Committee on Medical Testimony is of particular interest to all members of the Association. Its primary concern will be with the ethics and morals involving medical testimony by medical experts. The problem of widely divergent medical testimony of greater variance than honest difference of opinion seems to warrant has afforded both members of the legal profession and their clients a source of criticism. It has also given the courts and other governmental agencies a cause for confusion reflecting on the reputation of both the medical profession and the legal profession in the minds of the laity.

At the request of Dr. Jere W. Annis of Lakeland, while serving as President of the Association last year, this problem was investigated and discussed at length. The study culminated in a recommendation that a permanent Committee on Medical Testimony be established, corresponding to a similar committee of The Florida Bar. This progressive step to further justice and promote amicable relations between lawyers and doctors undoubtedly will be welcomed by the Association's membership and will, as pointed out by the Honorable O. B. McEwan, President of The Florida Bar, "redound to the benefit of both the medical and legal professions."

The following exchange of correspondence explains the details of this cooperative effort:

March 16, 1959

The Honorable O. B. McEwan, President
The Florida Bar
108 East Central Avenue
Orlando, Florida

Dear Mr. McEwan:

The Florida Medical Association announces the establishment of a standing "Committee on Medical Testimony." This Committee will concern itself with the ethics, morals and veracity of medical testimony given by experts and will review such testimony upon written request of counsel or the court.

In recognition of the problem with regard to medical testimony, it may be stated that in general, physicians strive to give honest and impartial testimony. However, on certain occasions divergent medical testimony may not permit honest differences of opinion and be the result of bias or misinformation. Justifiable criticism by the legal profession has arisen and confusion in the court has at times interfered with the proper administration of justice and inflicted discredit on both the medical and legal professions.

The Committee, being without punitive powers, will function in the following manner:

1. It will investigate medical testimony presented by any member of the FMA upon written request by any member of The Florida Bar, court representative, governmental agency or client involved, when it is charged that incorrect or biased testimony has been presented by the physician.
2. It will request the medical witness to appear before the committee and explain the reasons for his opinions and the divergence if any from other opinions or from the generally accepted medical facts.
3. It will advise both the physician charged and the party making the complaint of any unfounded grievance.
4. It will recommend to the FMA Judicial Council official reprimand of the physician when the charges are found to be justified, and will notify the party making the complaint of its action.
5. It will upon request serve in an advisory capacity to physicians desiring assistance in the proper manner of presenting medical testimony.

It is sincerely hoped that this committee will prove its value in improving our liaison and public relations with The Florida Bar.

Sincerely,
Jere W. Annis, M.D.
President

10 April 1959

Honorable Jere W. Annis, M.D., President
Florida Medical Association
P. O. Box 2411
Jacksonville 3, Florida

Dear Dr. Annis:

Your recent letter announcing the establishment of a standing Committee of the Florida Medical Association on Medical Testimony is most appreciated. We note that the Committee will concern itself with the ethics, morals and veracity of medical testimony given by experts and will review such testimony upon written request of counsel or the court. This measure can only redound to the benefit of both the medical and legal professions.

There can be no doubt that, in general, physicians strive to give honest and impartial testimony. Members of a learned profession who are dedicated to the alleviation of the suffering of mankind and to the pursuit of the truths of science could not do otherwise. This Committee will serve a valuable end both to resolve allegations arising out of an honest difference of opinion and to provide a forum in those rare cases where there may be an element of bias.

In the same spirit of cooperation we would like for you to advise the members of your association of the availability of the disciplinary procedures of The Florida Bar. The lawyers of Florida have been entrusted with the maintenance of the highest standards of professional ethics. Under the authority of the Supreme Court of Florida, The Florida Bar has established an official grievance committee in each of the judicial circuits of this State. We particularly invite any member of the medical profession who believes that a member of The Florida Bar has acted with impropriety to lay the facts before the appropriate grievance committee. Any complaint may be addressed to the office of the Executive Director in the Supreme Court Building in Tallahassee, and he will see that the matter is brought before the committee.

Establishment of the Committee on Medical Testimony will be another valuable step in the development of cordial relations between our professions.

Yours sincerely,
O. B. McEwan

New Medical Eye Care Pamphlet

The National Medical Foundation for Eye Care has a new pamphlet for popular distribution entitled "Why Drops?" Since it first appeared some four months ago, more than a quarter of a million copies have been purchased by ophthalmologist members of the Foundation for distribution to their patients. In the belief that the members of the Florida Medical Association will be interested to know that this pamphlet is available to them for their patients on request to the Foundation, 250 West 57th Street, New York 19, N. Y., the text is reproduced here in full:

Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to *enlarge the pupils,* so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the keyhole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to *relax the focussing muscles* in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. It is especially important in examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops in order to determine what glasses are required.

A third use of drops is to *anesthetize the eye,* to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the removal of foreign bodies and for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the *treatment of the eye.* Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine, and can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines *your* eyes can say whether drops are needed.

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

Federal Narcotics Registration Expires June 30

The Bureau of Internal Revenue, United States Government, has requested that physicians be reminded that their federal narcotics registration expires June 30, 1959. Renewal slips were sent to all physicians prior to May 15, and each doctor should be certain that his slip has been properly filled out, signed and returned before the expiration date of June 30. The registration fee may be returned with the slip.

OTHERS ARE SAYING

Good for the Patient — Good for the Doctor

While most people seem to have a high regard for their own personal physician they seem to look with a jaundiced eye at the medical profession at large. There is probably no simple, single answer to this paradoxical attitude, but it is interesting to speculate on the possibilities. One reasonable explanation is that to the public we actually are two different personalities, a Dr. Jekyl and a Mr. Hyde, as it were. Most doctors seated before their patients or at their bedsides present the picture of an intelligent individual, concerned about his patient and interested in his welfare even, sometimes, at the sacrifice of his own interest. This is Dr. Jekyl, the respected, admired and occasionally loved doctor whom the patient describes when he talks about his own doctor. But what about Mr. Hyde, or in this case, Dr. Hyde? He is that cool, impersonal "fat cat" who is more inaccessible by telephone than the President, and who when needed is either busy, out of town or unavailable. Is there any validity to these contrasting pictures? I believe there is.

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One of the most corrosive influences on a medical practitioner is the process of deification which gradually takes place over the years. As his practice grows "The Doctor" becomes a very important fellow, protected by his secretary, and sometimes by his wife, from interruption or disturbance by lesser important people known as patients. How often does one hear a doctor's secretary giving out with "Oh, The Doctor couldn't possibly see you for two weeks. He's all booked up and rushed to death." And then the potential patient who called up perfectly willing to pay his hard-earned money for a sympathetic ear for his own troubles has to listen to the problems of The Doctor. Most people still have an exaggerated idea about how many hours a doctor works, but such a brush-off doesn't set very well with the fellow who watches five or six doctors' foursomes teeing off for eighteen on a Wednesday, Thursday, Saturday or Sunday afternoon. The resentment which such an experience arouses is caused not so much by the fact that the doctor is enjoying the same recreation as his patients but that he is apparently unconcerned about his patient except at his own convenience. Whether this attitude is justified or not is academic. It exists and something should be done about it.

The petroleum industry has shown real insight into public thinking in popularizing its gasoline dispensatories as service stations. Not a place where gasoline is sold but where service is rendered. What a boon to medical public relations it would be if each doctor's office should become known as a "service station for the sick!" The accomplishment of this is not difficult. All it requires is a change in attitude. A change from the rarified, protectionist atmosphere about The Busy Doctor to a "We're glad you called and we're sorry we can't see you, but we'll be glad to help you find another doctor" atmosphere where the patient is made to feel that he is the doctor's reason for being.

I am convinced that the Dr. Jekyl picture is more characteristic of most doctors than the Dr. Hyde. The practice of courtesy and consideration in the doctor's office, especially by his secretary and nurses and particularly to people whom the doctor never sees, will do a great deal toward erasing the Dr. Hyde picture and toward letting the public see that the austere fellow driving the big car is the same warm and human fellow sitting behind the doctor's desk.

(Continued on page 1444)

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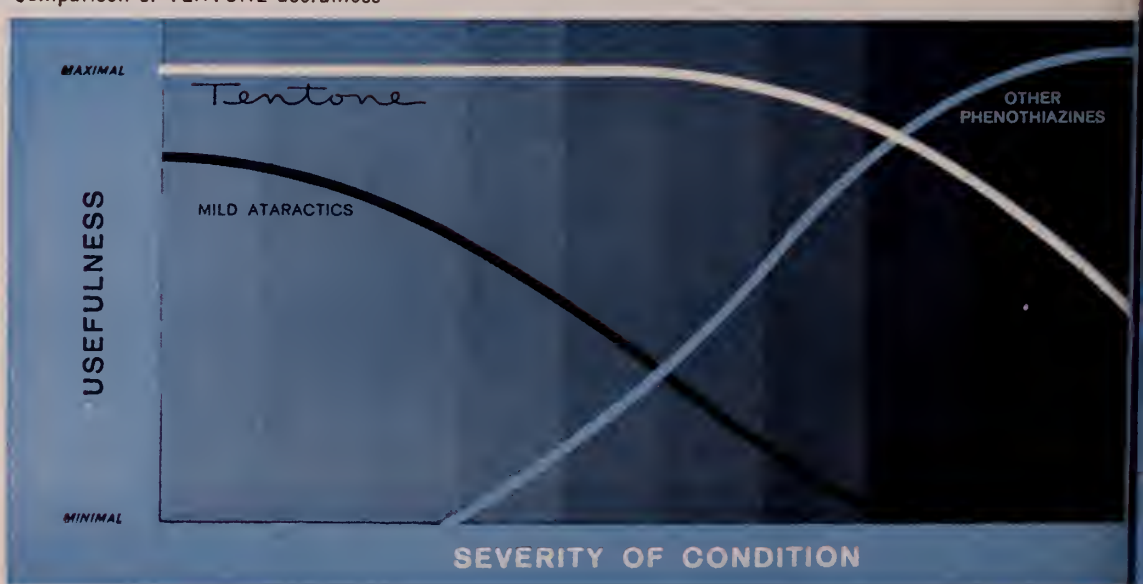
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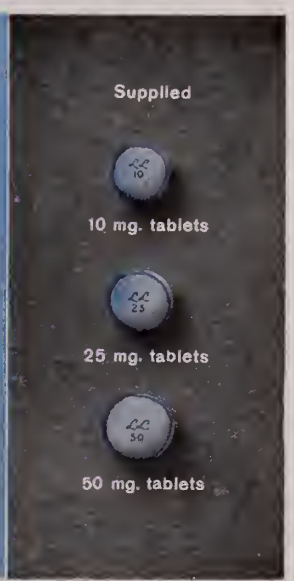
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◆ Positive, rapid calming effect in mild and moderate cases. ◆ Striking freedom from organic toxicity, intolerance, or sensitivity reaction—particularly at low dosage. ◆ Greater freedom from induced depression or drug habituation. ◆ May be useful, as with other tranquilizers, to potentiate action of analgesics, sedatives, narcotics. ◆ Facilitates management of surgical, obstetric, and other hospitalized patients. ◆ Indicated when more than a mild sedative effect is desired...and less than psychosis is involved. ◆ Dosage range: *In mild to moderate cases:* from 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to 500 mg. daily.

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(Continued from page 1440)

As medical practice becomes more mechanized and as more "third parties" are introduced between doctor and patient, the picture that the patient gets of the doctor becomes more disturbed. If the traditional picture of the dedicated man of medicine (and I am convinced that he is as dedicated today as he ever was) is to be preserved, it is essential that the interest which the doctor himself has in his patient is equally manifested by all auxiliary people helping him to provide medical care. To paraphrase Mr. Wilson "That which is good for the patient is also good for the doctor." When the public can be convinced that we feel that which is in the public interest is also in the interest of the medical profession we shall have no further need for the services of professional public relations experts to tell our story.

Robert E. Zellner, M.D., President
The Bulletin
Orange County Medical Society
Oct., Nov., Dec., 1958.

BLUE SHIELD

Participating Physicians Manual

FORMS, Forms, Forms. Electronic marvels in the modern business office inexplicably seem to have increased paperwork. Blue Shield, too, wishes that it were possible to reimburse Participating Physicians for their services without asking them to complete and submit the Doctor's Service Report.

Although Blue Shield has yet to find a way to obtain this necessary information without a report from the physician, every effort is being made to conserve the doctor's time to the greatest degree possible. Toward this objective a new Participating Physicians Manual has been prepared and has been mailed to each Participating Physician in Florida. In loose leaf form this manual will serve as a ready reference to physicians and their secretaries on many aspects of Blue Shield, including the new higher income level, increased benefits "A" contract. In addition to the schedule of benefits on all Blue Shield contracts in effect—the "A," the "J" and the "F" —the manual contains specimen forms and contracts and a detailed explanation of how to complete the Doctor's Service Report.

Under the direction of the recently organized Physician Relations Department every effort is

83% MAJOR (Grade I and II) IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL**® or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

Write for Booklet.

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nd of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

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Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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being made to assist the physician in implementing the new "A" contract and in effectively utilizing the Participating Physicians Manual. Four representatives of this department are available to physicians and their secretaries at all times to give personal attention to Blue Shield problems. Realizing that a well informed secretary will be invaluable in conserving the doctor's time, the Physician Relations Department has recently completed 32 dinner meetings throughout the state for approximately 3,000 medical assistants and secretaries. These workshops have provided doctors' assistants an excellent opportunity to become better versed on the origin and history of Blue Shield, on the details of the "A," "J" and "F" contracts, and, most of all, on how the Physician Relations Department can be invaluable to the secretary and to her doctor employer.

The new manual can answer many Blue Shield questions. Use it.

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando, President-Elect of the American Medical Association, was one of the principal speakers at the 91st annual meeting of the Mississippi State Medical Association held May 12-14 at Biloxi. Prior to the speaking engagement in Mississippi, Dr. Orr was in Atlanta where he addressed an area medical meeting of the American Cancer Society.

Dr. James N. Patterson of Tampa was in Boston April 16-18 to give examinations of the American Board of Pathology and to attend the 56th annual meeting of the American Association of Pathologists and Bacteriologists and the 48th annual meeting of the International Academy of Pathology.

The University of Miami School of Medicine has received a quarter million dollar grant in aid from the U. S. Public Health Service for a five year study in new technics for the use of drugs in the treatment of cancer. The work will be under the direction of Dr. Daniel S. Martin, Associate Professor of Surgery.

Dr. Seymour Morse of Jacksonville was guest speaker at the annual meeting of the Duval County Chapter of the Muscular Dystrophy Association held recently in Jacksonville.

(Continued on page 1452)

"...iodides
and hot liquids
—[among]
the best
friends
an asthmatic
ever had."[1]



FREE YOUR ASTHMATIC PATIENT
FROM SECRETORY OBSTRUCTION
ENCOURAGE BRONCHIAL EVACUATION

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solution and tablets — iodinated glycerol, organically bound iodine

THE WELL TOLERATED[1] IODIDE EXPECTORANT—"Wheezing" or "hacking" coughs respond most favorably to specific antitussive medication plus the "excellent bronchial evacuants"[2] —iodides—a most clinically effective type of expectorant.[3] For excellent results, add stable Organidin—organically bound iodine—to your favorite cough therapy. Organidin is better-tasting, better tolerated than inorganic iodides. Full dosage may be given immediately. ORGANIDIN solution is freely miscible with common syrups. **SUPPLIED:** Solution, bottles of 30 cc.; Tablets, bottles of 100. **DOSAGE:** See Physicians' Desk Reference, 1959, p. 847. (1) Seltzer, A.: M. Ann. District of Columbia **26**:17 (Jan.) 1957. (2) Segal, M. S.: J.A.M.A. **169**:1063 (Mar.) 1959. (3) McLean, J. A.: GP **18**:128 (Dec.) 1958. For professional samples and literature write:

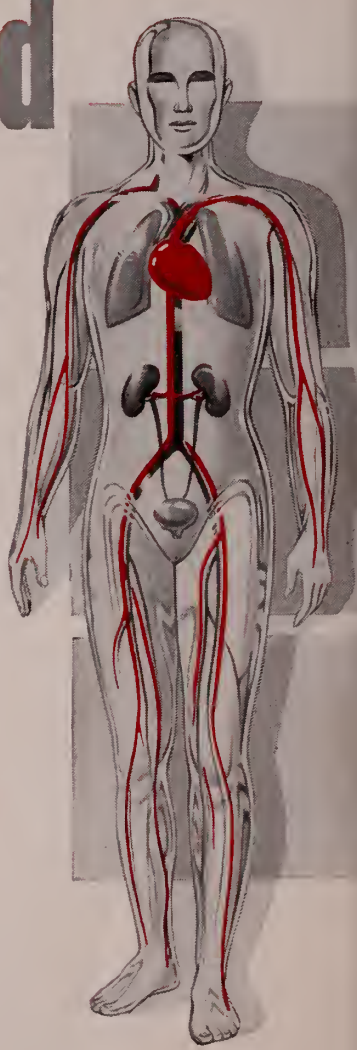
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HYDRODIURIL®

(HYDROCHLOROTHIAZIDE

simplifies* and improves any regimen for hypertension



*it's as easy as 1, 2, 3 to use

HYDRODIURIL™

(HYDROCHLOROTHIAZIDE)

1 Initiate therapy with HYDRODIURIL: one 25 mg. tablet or one 50 mg. tablet once or twice a day. HYDRODIURIL by itself often causes an adequate drop in blood pressure over a period of two to three weeks. This may be all the therapy some patients require.

2 Add or adjust other agents as required: HYDRODIURIL enhances the activity of all commonly-used antihypertensive agents; thus, the dosage of other medication (rauwolfia, reserpine, hydralazine, veratrum) should be initiated or adjusted as indicated by patient condition. If a ganglion-blocking agent is contemplated or being used, usual dosage must be reduced by 50 per cent.

3 Adjust dosage of all medication: the patient must be frequently observed and careful adjustment of all agents should be made to establish optimal maintenance dosage.

Supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000.
Additional literature for the physician is available on request.

HYDRODIURIL is a trademark of Merck & Co., Inc. Trademarks outside the U. S.: DICHLOTRIDE, DICLOTRIDE, HYDROSALURIC.

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A SINGLE ANTIBIOTIC... permitting flexible, controlled dosage as needed... free from restrictions of fixed combinations... for optimum tetracycline levels... unsurpassed effectiveness covering at least 90 per cent* of antibiotic-susceptible infections seen in general practice.

Supplied: Capsules of 250 mg. with 250 mg. citric acid and 100 mg. with 100 mg. citric acid.

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*Based on a twelve-month National Physicians Survey.

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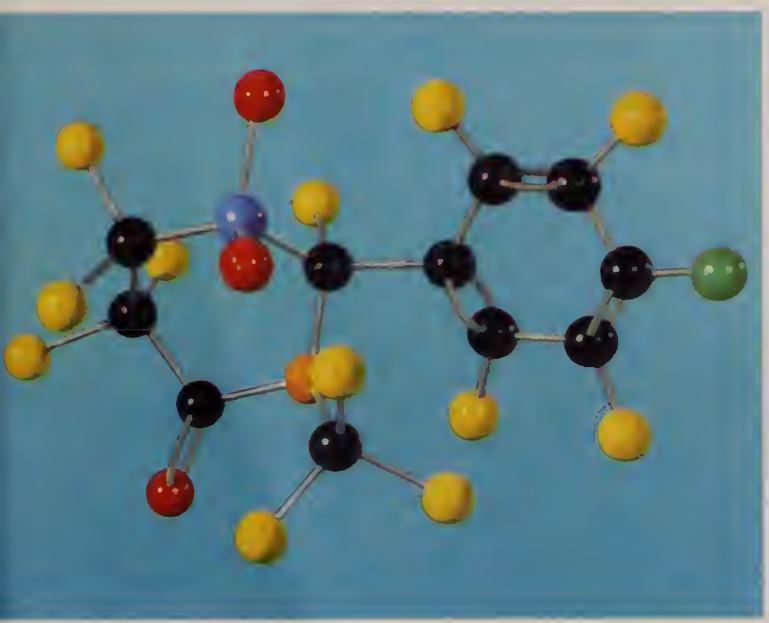
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low back pain
and
dysmenorrhea

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*the first true tranquilaxant**

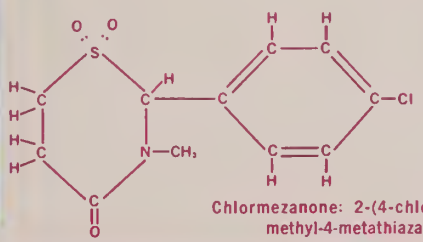
***Potent* MUSCLE RELAXANT**
***... Equally effective as a* TRANQUILIZER**

***tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new, orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Clinical studies of over 4400 patients by 105 physicians[1] proved Trancopal remarkably effective in musculoskeletal conditions, anxiety and tension states.

MUSCULOSKELETAL DISORDERS

effective in

93%

of 1570 documented cases of

LOW BACK PAIN

(LUMBAGO, SACROILIAC DISORDERS)

By relieving muscle spasm and pain, Trancopal permits early and active exercise and physical therapy to accomplish maximal benefits for rapid recovery.

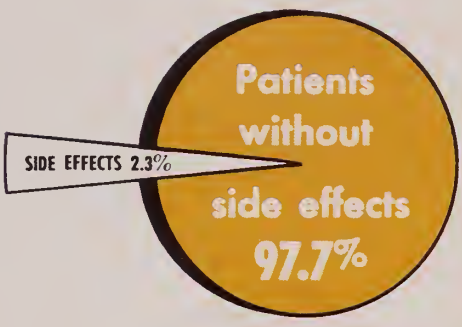
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the first true tranquilaxant

BETTER TOLERATED AND SAFER THAN OLDER DRUGS

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work—or play. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4483 PATIENTS



ANXIETY AND TENSION STATES

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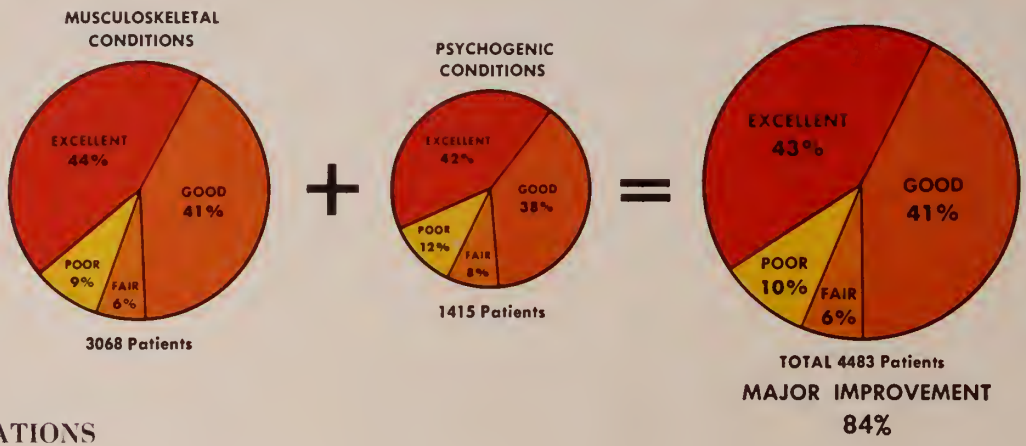
AND PREMENSTRUAL TENSION

Because of its exceptional calmative property, Trancopal "... allows the patient to use his energies in a more productive manner in overcoming his basic problems."[2]

Dosage: 1 or 2 Caplets (100 mg.) orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Thoroughly evaluated clinically...

Clinical studies of 4483 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.



INDICATIONS

Musculoskeletal

- Low back pain (lumbago)
- Neck pain (torticollis, etc.)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disk syndrome
- Fibrositis
- Ankle sprain, tennis elbow, etc.
- Myositis
- Postoperative muscle spasm

Psychogenic

- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Angina pectoris
- Alcoholism

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E.: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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MUSCLE RELAXANT
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Safe, potent antibacterial action proven effective in 95% of all urinary tract infections.

Prompt relief of spasm all along the urinary tract.

Specific urinary analgesic action relieves burning and pain within minutes.

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Uriplex, in addition to accomplishing these major objectives, offers more rapid and complete control of urgency and frequency because of its simultaneous relief of both pain and spasm.

Each Uriplex coated tablet contains:

Sulfacetamide	250 mg.
Methscopolamine Nitrate	1 mg.
Phenylazodiaminopyridine HCl	50 mg.

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(Continued from page 1446)

Dr. Julian A. Rickles of Miami served as one of the instructors for the Individual Survival Training Class given in a local high school early in March.

Dr. James H. Ferguson of Miami presented a paper on "The Technique and Place of Cervical Cone Biopsy in Obstetrics and Gynecology" before the Section on Obstetrics and Gynecology of the 91st annual meeting of the Mississippi State Medical Association held May 12-14 at Biloxi. Dr. Ferguson was one of the speakers at the meeting of the American Association of Obstetricians and Gynecologists held the middle of March in San Francisco.

Dr. George W. Karelas of Newberry attended the 14th national rural health conference held at Wichita, Kansas, early in March.

The University of Miami School of Medicine will conduct a demonstration program in geritarics under a grant of more than $30,000 from the National Institute of Health. Dr. Samuel Gertman, Clinical Assistant Professor of Geriatrics and Director of the Geriatric Institute, will be in charge of the new project whose goal will be primarily the maintenance of health rather than the solution of particular disease problems.

Dr. Edward R. Woodward of Gainesville, Professor and Head of the Department of Surgery of the College of Medicine, University of Florida, discussed "Practical Applications of Physiological Principles to Gastric Surgery" on the program of the Section on Surgery of the 91st annual meeting of the Mississippi State Medical Association held May 12-14 at Biloxi. Dr. Woodward also served as a member of the panel which discussed "Technical Mishaps Occurring During Surgery: Recognition and Management."

Dr. Robert E. Raborn of Delray Beach discussed the need for research in diseases of the cardiovascular system at a recent meeting of the Rotary Club of that city.

The American Association of Blook Banks will hold its 12th annual meeting November 4-7 at the Edgewater Beach Hotel in Chicago. Physicians interested in presenting papers should contact Dr. Alan Richardson Jones, 332 Longwood Ave., Boston 15, Mass., prior to June 30.



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the first oral antifungal antibiotic for ringworm

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*T.M. S 224

Dr. George R. Crisler of Winter Park was guest speaker at the March meeting of the Mental Health Association held in Orlando. His topic was "Peace of Mind."

The Woman's Hospital Division of St. Luke's Hospital, New York City, offers a course in "The Conduct of Labor and Delivery" October 8-14 for physicians engaged in general practice. Thirty hours Category I credit is allowed. Information may be obtained from Mr. Carl P. Wright Jr., Director, Woman's Hospital, 141 West 109th St., New York City.

Dr. John A. Dyal Jr. of Perry, secretary of the Taylor County Medical Society, was in charge of arrangements for the program of a March meeting of the Rotary Club of that city. Two physicians appeared on the program, Dr. John McCormick of Jacksonville, and Dr. Frederich Karl Vontz, formerly of Germany, but now living in Jacksonville.

Dr. H. Phillip Hampton of Tampa participated in the series of lectures sonsored by the Hillsborough County Medical Association and the Hillsborough County Nutrition Committee on the subject "Food Facts and Fallacies." The subject of the lecture by Dr. Hampton was "Fad Cures." The series began early in March.

Dr. Edmund P. Kelley of Sarasota and Dr. Joseph E. Duke of Bradenton were principal speakers at a recent meeting of the Manatee County Lay Diabetes Society. Their subject was "Diabetes and Quackery."

Dr. James J. DeVito of St. Augustine was principal speaker at a March meeting of members of District 11 of the Florida Nurses Association held at St. Augustine.

Dr. John H. Mickley of Hollywood addressed a recent meeting of the Hallandale Kiwanis Club on the subject "The Medical Examiner's Office and the Private Citizen."

Dr. A. M. C. Jobson of Tampa has returned from New Orleans where he attended the New Orleans Graduate Medical Assembly.

Dr. Courtland D. Whitaker of Marianna has been presented the Silver Beaver Award by the

the "full-range"
oral hypoglycemic agent

DBI

Trademark, brand of Phenformin

in the management of
mild, moderate and severe diabetes
(juvenile and adult)

Southeast Alabama Council of the Boy Scouts of America. The selection of Dr. Whitaker was "due to his devotion to his community in general and scouting in particular, and for outstanding accomplishments in all areas of his service."

Dr. Victor H. Kugel of Miami Beach served as moderator for the heart forum presented at Miami Beach as a public service recently. Panelists included Drs. Robert J. Boucek, Robert S. Litwak and Paul N. Unger of Miami Beach, and Drs. William M. Straight, Milton S. Saslaw and Peter Steincrohn of Miami.

Dr. L. Roland Young of Daytona Beach attended the symposium on "Recent Advances and Their Office Application" held April 19 at Miami Beach.

The University of Miami School of Medicine has announced the opening of an audiology clinic at 1411 N. W. 14th Ave. in Miami with Dr. Otto J. Menzel as director. All types of diagnostic testing will be conducted by the clinic, however, Dr. Menzel states that emphasis will be on hearing aid evaluation and consultation. Services are available on referral from a practicing otologist.

Dr. Charles F. Tate Jr. of Miami has been elected president of the Florida Trudeau Society succeeding Dr. Kip G. Kelso of Vero Beach. Other newly elected officers include Dr. George H. McCain of Tallahassee, vice president, and Dr. Allen Y. DeLaney of Gainesville, secretary. Dr. Howard M. DuBose of Lakeland has been appointed as representative to the American Trudeau Society.

Dr. Walter W. Sackett Jr. of Miami has been appointed vice president of the General Practice Section of the North American Division of the Pan American Medical Association.

Dr. Victor D. Dembrow of Miami attended the recent meeting of the Society of Head and Neck Surgeons held in Washington, D. C., and the James Ewing Cancer Society in New York City.

Dr. Meredith F. Campbell of Miami was an invited participant in the program of the Southeastern Section of the American Urological Association held April 1 in Louisville, Ky. Dr. Campbell was a member of the panel for discussion of pediatric urology.

DBI (N^1-β-phenethylbiguanide HCl) is an entirely new oral hypoglycemic compound, different in chemical structure, mode of action, and in spectrum of activity from the sulfonylureas. DBI is usually effective in low dosage range (50 to 150 mg. per day).

"full-range" hypoglycemic action — DBI lowers elevated blood-sugar and eliminates glycosuria in mild, moderate and severe diabetes mellitus . . .

brittle diabetes, juvenile or adult — DBI combined with injected insulin improves regulation of the diabetes and helps prevent the wide excursions between hypoglycemic reactions and hyperglycemic ketoacidosis.

stable adult diabetes — satisfactory regulation of diabetes is usually achieved with DBI alone without the necessity for insulin injections.

juvenile diabetes — DBI often permits a reduction as great as 50 per cent or more in the daily insulin requirement.

primary and secondary sulfonylurea failures — DBI alone, or in conjunction with a sulfonylurea, often permits satisfactory regulation of diabetes in patients who have failed to respond initially or who have become resistant to oral sulfonylurea therapy.

smooth onset — less likelihood of severe hypoglycemic reaction — DBI has a smooth, gradual blood-sugar lowering effect, reaching a maximum in from 5 to 6 hours, and a return to pretreatment levels usually in 10 to 12 hours.

safety — daily use of DBI in therapeutic dosage for varying periods up to 2½ years has produced no clinical toxicity.

side reactions — side reactions produced by DBI are chiefly gastrointestinal and occur with increasing frequency at higher dosage levels (exceeding 150 mg. per day). Anorexia, nausea or vomiting may occur — but these symptoms abate promptly upon reduction in dose or withdrawal of DBI.

supplied — DBI, 25 mg. scored, white tablets — bottle of 100.

IMPORTANT — before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.

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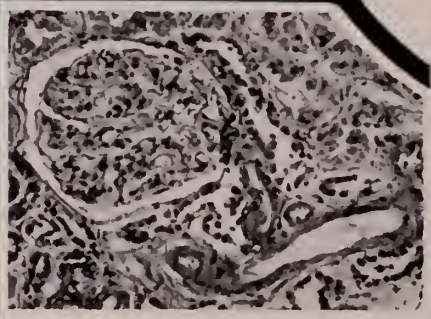
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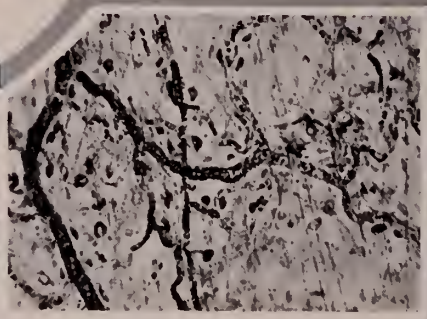
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THUS SQUIBB OFFERS YOU GREATER LATITUDE IN SOLVING THE PROBLEM OF

HYPERTENSION

WITHOUT FEAR OF SIGNIFICANT POTASSIUM DEPLETION[1-3]

Rautrax combines Raudixin with flumethiazide — *the new, safe nonmercurial diuretic* — for control of all degrees of hypertension. Clinicians report it safely and rapidly eliminates excess extracellular sodium and water without potassium depletion.[1-3] Potassium loss is less than with any other nonmercurial diuretic.[1] Moreover, the inclusion of supplemental potassium chloride in Rautrax provides added protection against potassium and chloride depletion in the long-term management of hypertension.

Through this dependable diuretic action of flumethiazide, the clinical and subclinical edema — so often associated with cardiovascular disease — is rapidly brought under control.[2-5] And once Rautrax has brought the fluid balance within normal limits, continued administration does not appreciably alter the normal serum electrolyte pattern. Flumethiazide also potentiates the antihypertensive action of Raudixin. By this unique dual action, a lower dosage of each ingredient effectively maintains safe antihypertensive therapy.

Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.

Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.

References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

LITERATURE AVAILABLE ON REQUEST.

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around the clock ulcer control with **B.I.D.** *dosage*



Just one 10 mg. Daricon tablet in the morning, and one at night before retiring, keeps your patient free from the pain and discomfort caused by gastrointestinal spasm, hypermotility, and hypersecretion.

Daricon is a remarkably potent and well tolerated antisecretory/antimotility agent. Its *naturally* prolonged action provides day and night relief of pain and symptoms associated with peptic ulcer, functional bowel syndrome, biliary tract dysfunctions, ulcerative colitis, and other gastrointestinal disorders characterized by spasm, hypermotility, and hypersecretion.

Dosage: 10 mg. b.i.d. (morning and evening).

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Brooklyn 6, New York

References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

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OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { LOTION: Plastic squeeze bottles of 20 cc.
POWDER: Shaker-top bottles of 10 Gm.



OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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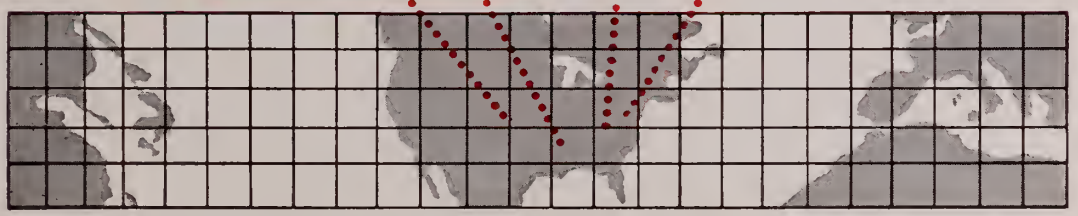
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"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

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"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior . . ."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety . . . Its safety makes it an excellent drug for out-patient use in office practice."[4]



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For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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No dangerous side effects.

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see Page 666

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Effective relief in rheumatic disorders

Sterazolidin® capsules
prednisone-phenylbutazone Geigy

Geigy

with less risk of disturbing hormonal balance



In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

Repeatedly it has been shown that the addition of low dosage of Butazolidin sharply reduces hormone requirement.[1-4] Sterazolidin is a combination of prednisone (1.25 mg.) and Butazolidin (50 mg.) which provides, in the majority of cases, consistent relief at a stable uniform maintenance dosage significantly below the level at which serious hormonal imbalance is likely to occur.

Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

6980

COMPONENT SOCIETY NOTES

Brevard

Dr. Newton C. McCollough of Orlando was principal speaker for the April meeting of the Brevard County Medical Society held at Cocoa Beach. The title of his address was "Low Back Pain."

Columbia

The Columbia County Medical Society has paid 100 per cent of its state dues for 1959.

Hillsborough

Dr. Edward R. Annis of Miami addressed the members of the Hillsborough County Medical Association at their May meeting held at Tampa. Dr. Annis discussed the topic of health and insurance.

Polk

Dr. Milton S. Saslaw of Miami addressed the members of the Polk County Medical Association at the February meeting in Lakeland. The subject of his address was rheumatic fever and heart disease.

Pinellas

Dr. George Miller, Professor of Urology, College of Medicine, University of Florida, Gainesville, was principal speaker at the June meeting of the Pinellas County Medical Society. The title of his address was "The Non-Surgical Treatment of Urinary Tract Stones."

St. Johns

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, was principal speaker at the April meeting of the St. Johns County Medical Society held at St. Augustine.

Dr. Arthur C. DeGraff, Professor of Therapeutics at New York University College of Medicine, addressed members of the Society at their February meeting held at the home of Dr. Joseph A. Shelley, secretary of the Society. Dr. DeGraff's subject was methods of treatment of heart disease.

Volusia

Dr. Don C. Robertson of Orlando, councilor for the Fourth District of the Florida Medical Association, was principal speaker on the program for the April meeting of the Volusia County Medical Society. The meeting was held near DeLand.

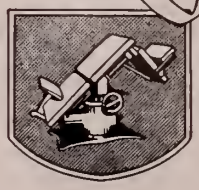


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with low incidence of sensitivity reactions... Extremely low in toxic potential. [2,3] No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity. [2] Even minor subjective reactions are not expected to occur [2] or are reported absent [3] when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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Advertising rates for this column are $5.00 per insertion for ads of 25 words of less. Add 20c for each additional word.

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GENERAL PRACTITIONER: To join two young General Practitioners in growing 3 year old practice. Small community, north Florida. Modern 30 bed community hospital adjacent to office. Time off for postgraduate study. Write 69-289, P.O. Box 2411, Jacksonville, Fla.

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FOR RENT: Two medical suites, ground floor, in new air conditioned medical building. Large reception room, furnished. Suburban St. Petersburg-Clearwater. Write Midway Medical Center, Box 8192, Madeira Beach, Fla.

WANTED: General Practitioner in rapidly growing South Florida community. 4500 white population in ten mile area. Practice well established. Florida license required. Write Chamber of Commerce, Lake Placid, Fla.

FOR SALE: Fully equipped modern office in Northwest Miami (Opa Locka). A rapidly growing residential and industrial area. Lenient terms. Write 69-318, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Office Equipment - Bargain. 1 Hamilton Pediatric table, 1 cabinet, desks, chairs, scales, filing cabinets, 1 small biological refrigerator, etc. H. L. Tippins, M.D., 801 N. W. 47th St., Miami 37, Fla. Phone PL 8-5892.

GENERAL PRACTITIONER WANTED: In upper West Coast town of 2,000 population near Tallahassee, Gainesville (new Teaching Hospital and Medical School) and Perry. One of present doctors due to retire soon and other overworked. Phone or write Spurgeon Cheek, Dixie County Chamber of Commerce, Cross City, Fla.

INTERNIST WANTED: Certified or Board eligible, Florida licensed to associate with established Internist in Palm Beach area. Unusual opportunity. State all details. Write 69-319, P. O. Box 2411, Jacksonville, Fla.

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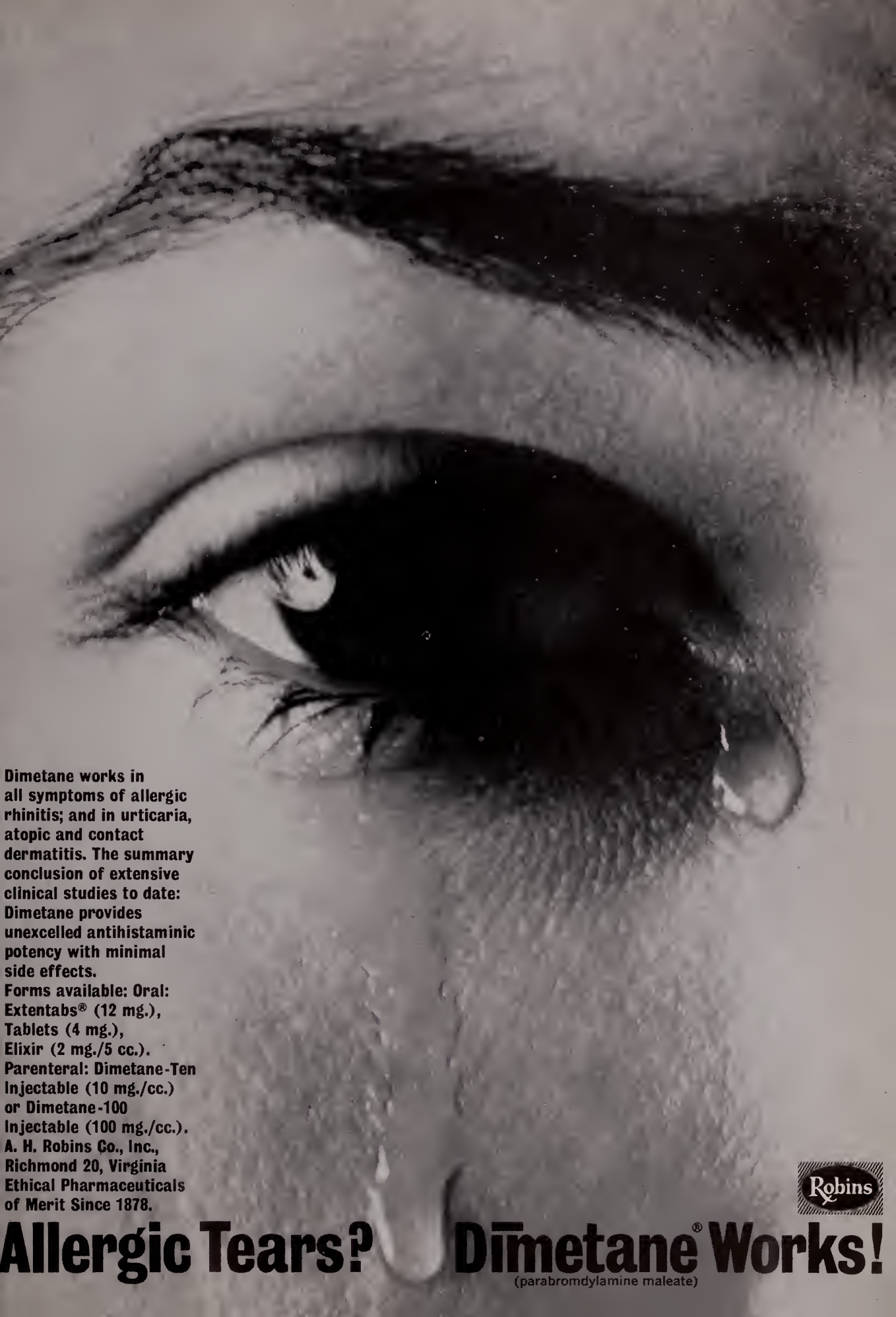
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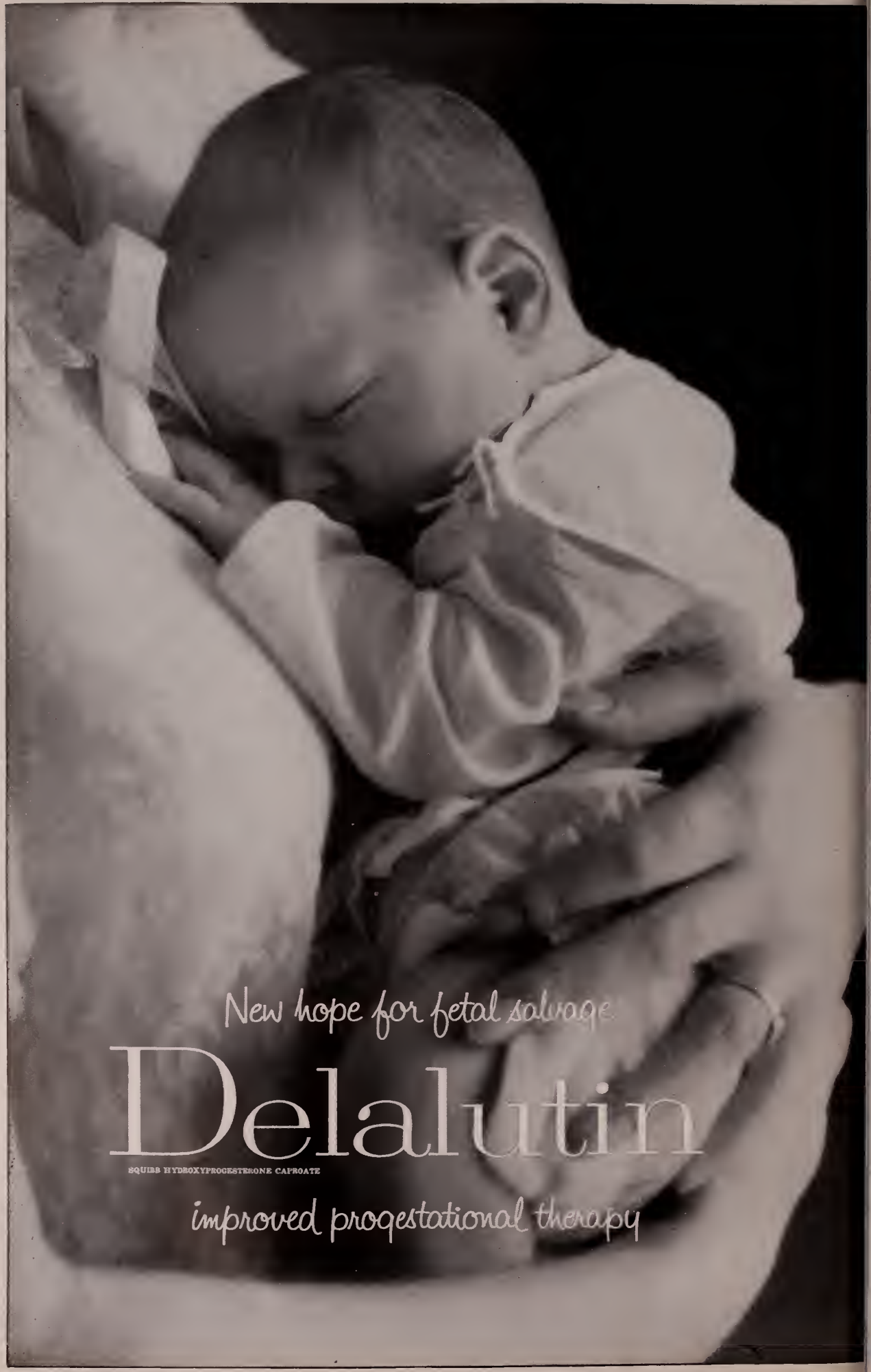
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Each package of Depinar consists of a multiple dose vial, containing cyanocobalamin zinc tannate (lyophilized), equivalent to 2500 mcg. vitamin B_{12}. The vial of diluent contains 5 cc. Sodium Chloride Solution for Injection. When reconstituted, each ml. of Depinar contains 500 mcg. vitamin B_{12}.



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New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'Delalutin'® is a Squibb trademark

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Barnes, Claude J., Milton
Berley, Ferdinand V., Jacksonville
Bush, Charles W. Jr., Lauderdale by the Sea
Carr. George L., Pensacola
Cella, Charles F., Pompano Beach
Citrin, Yale, Hollywood
Corson, Richard H., Orlando
Dance, Clifton L. Jr., Ft. Lauderdale
de Olazarra, Allen C., Kendall
Figueroa, Miguel Jr., Miami
Flanagan, Curtis J., Ft. Lauderdale
Hoff, Theodore F., Orlando
Jones, Jenner G., Orlando
Kulvin, Max M., Miami
Larson, Eli, Miami
Leb, Samuel, Miami Beach
Leitheiser, Karl A., Orlando
Morris, John de L., Tampa
Newell, Charles H., Jacksonville
Reichling, Raymond J. Jr., Rockledge
Reid, James R. Jr., Jacksonville
Rodda, Thaddeus S., Fort Myers
Rubin, Herbert E., Gulfport
Sacks, Sidney, Miami Beach
Thomas, William C. Jr., Gainesville
Ulseth, Robert N., West Palm Beach
Walls, Fred Jr., Orlando
Weems, Nathaniel M. Jr., Boynton Beach
Willard, Benjamin C. Jr., Orlando

BIRTHS AND DEATHS

Births

Dr. and Mrs. George Gittelson of Miami announce the birth of a son, Gary, on January 31, 1959.

Dr. and Mrs. Joseph Allison of Miami Beach announce the birth of a daughter, Julie Wynne, on March 10, 1959.

Dr. and Mrs. James G. Robertson of Miami announce the birth of a daughter, Lisa Florice, on February 25, 1959.

Dr. and Mrs. John T. Stage of Jacksonville announce the birth of a son, Thomas Gallatin, on April 4, 1959.

Member Deaths

Hughes, Robert L., Bartow	Jan. 6, 1959
Kells, Paul, Miami	Dec. 29, 1958

Other Doctors

Eakins, Olin Martin, Miami Beach	Dec. 23, 1958
Hawk, Alpha F., Micco	Dec. 16, 1958
Orlick, Abraham P., Miami Beach	Feb. 13, 1959
Witt, Dea C., High Springs	April 6, 1959



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Assures patient's cooperation

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OBITUARIES

Ammon Buist Litterer

Dr. Ammon Buist Litterer of Miami died at his home in Coral Gables on Jan. 1, 1959. He was 61 years of age.

A native of Tennessee, Dr. Litterer was a member of a distinguished medical family of Nashville, where he was born on Sept. 12, 1897. His father, Dr. William Litterer, a pioneer pathologist, was best known in medicine for introducing into this country the Pasteur treatment for rabies. As had his two older brothers, Henry and William, he received his medical training at Vanderbilt University School of Medicine, where he was graduated in 1923. Upon completion of his graduate work, he studied pathology with his brothers.

In 1926, Dr. Litterer located in Miami, where he served as pathologist to St. Francis, Victoria and Jackson Memorial hospitals. Later, he specialized in dermatology and continued to practice in that field of medicine until his death. Locally, he was a member of the First Methodist Church of Coral Gables and served as a member of its official board. He was a member of the Army and Navy Club, the American Legion and the American Legion 40 & 8.

An early member of the U. S. Naval Reserve, Dr. Litterer was called into service in World War II immediately after Pearl Harbor. He remained in the inactive Reserve after the war and served as Senior Naval Medical Officer for the Miami unit until his retirement with the rank of captain in 1957.

Dr. Litterer was a member of the Dade County Medical Association and had held membership in the Florida Medical Association for 33 years. He also held membership in the American Medical Association and was a past president of the Florida Society of Dermatology.

Surviving are the widow, Mrs. Carolyn Litterer, a son, three sisters, and a grandchild.

Walter Louis Alspach

Dr. Walter Louis Alspach of Miami died of cancer at his home on Feb. 11, 1959. He was 64 years of age.

(Continued on page 1478)

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MICRONITE FILTER:

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During the past year, Kent sales increased by 20-billion cigarettes—the greatest gain in popularity ever recorded by any filter cigarette in any year.

Undoubtedly much of the credit for this important rise in sales must go to Kent's exclusive "MICRONITE" Filter. This extraordinary new filter was constructed to take into account new principles of filtration which were dictated by the basic discoveries of a major research foundation, working under Lorillard sponsorship.

The foundation determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Additional research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the exclusive Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. In this maze-like network of superfine fibers the smoke particle has much less chance to slip through the filter.

Thus, Lorillard research created a filter which reduced tars and nicotine in the "inhaled" smoke to the lowest level among the largest selling brands. As smokers learned about the "MICRONITE" Filter, they changed to Kent. During the past year, for instance, more smokers changed to Kent than to any other cigarette in America.



If you would like for your own use the booklet, "The Story of Kent," write to:
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A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

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"Good for you!"

CONGRATULATIONS! What a moment. What a day. Now relax. You've earned it. Reward yourself with a good glass of beer. Doesn't it taste wonderful? Nothing, but nothing takes care of that great big thirst of yours like a long, cold glass of beer. And—it really picks you up too.

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Beer's rich in wonderful, healthful things. Nature's own choice barley malt, hops, minerals, and the purest water. Good wholesome beer or ale perks you up—won't let you down.



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where apprehension increases tension...
patients respond well to

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EFFECTIVENESS AND SAFETY Vistaril establishes relaxed indifference to preoperative preparation without serious hypotensive effects.

PSYCHOTHERAPEUTIC POTENCY Vistaril makes possible the maintenance of an adequate degree of narcosis with reduced doses of narcotics.
Vistaril relieves tension and controls emesis in both postoperative and postpartum patients.

Recommended Oral Dosage: up to 400 mg. daily in divided doses.

Recommended Parenteral Dosage: 25-50 mg. (1-2 cc.) I.M., q. 4 h., p.r.n.

Vistaril is supplied in 25 mg., 50 mg., and 100 mg. capsules. The parenteral solution is available in 10-cc. vials and 2-cc. Steraject® cartridges; each cc. contains 25 mg. hydroxyzine (as the HCl).

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

(Continued from page 1472)

Born in Buffalo, N. Y., on Nov. 8, 1894, Dr. Alspach attended local schools. He received his medical training at the University of Buffalo School of Medicine and was graduated in 1918. There followed a period of serious illness and then several years of study in Europe. For 10 years after his return, he practiced in various regions of the United States before settling in Pascagoula, Miss. He left there in 1946, after strenuous practice during the war years, in order to retire in Miami. Tiring of leisure after a few years, he returned to the practice of internal medicine and continued in active practice there until illness forced his retirement last year. Locally, he was a member of the Surf Club and of the Committee of One Hundred.

Dr. Alspach became a member of the Dade County Medical Association and of the Florida Medical Association in 1952. He also held membership in the American Medical Association, the Southern Medical Association, the Mississippi State Medical Association and the Greater Miami Heart Association.

Survivors include the widow, Mrs. Virginia Alspach, of Miami; two sons, Philip H. Alspach of Pittsfield, Mass., and Dr. Bruce W. Alspach of Miami; one brother, Herman Alspach of Buffalo; and five grandchildren.

Theodore Richard Failmezger

Dr. Theodore Richard Failmezger of Clearwater met accidental death on Feb. 7, 1959. He was 54 years of age.

Born in Brooklyn, N. Y., on Aug. 20, 1904, Dr. Failmezger was graduated from Columbia University College of Pharmacy in 1926 and for a time served as an instructor in chemistry at that institution. In 1930, he was awarded the B.S. degree by Polytechnic Institute of Brooklyn, and in 1934 the degree of Doctor of Medicine was conferred upon him by Jefferson Medical College of Philadelphia. After serving an internship at Orange Memorial Hospital and a residency in medicine at New York Post Graduate Hospital, he entered the private practice of medicine in 1936 in Madison, N. J., where he was physician to Drew University from 1937 to 1957. He was a member of Kappa Psi, Omega Upsilon Phi, the Masonic and Elks lodges, and the Madison Methodist Church.

In 1942, Dr. Failmezger was commissioned a major in the Army of the United States. During



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1. Bandes, J.: Combined Drug Therapy in Gastrointestinal Disturbances; Increased benefit through diminished side reactions, Am. J. Gastroenterology, *30*:600, Dec. 1958.



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World War II, he served as chief of medical service and later as commanding officer of the 116th Station Hospital, retiring from active duty with the rank of lieutenant colonel.

In October 1957, Dr. Failmezger came to Florida and opened an office in Clearwater, where he was on the staff of Morton Plant Hospital and was affiliated with the First Methodist Church. He was a member of the Pinellas County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association, the American Rheumatism Association and the American Geriatrics Association. He was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

Dr. Failmezger is survived by his widow, the former Hilda B. Rhinesmith, and two sons, George Richard Failmezger, a law student at the University of Virginia, and Theodore Charles, a freshman at Dartmouth College, Hanover, N. H.

Herbert Eichert

Dr. Herbert Eichert of Miami met sudden death in an automobile accident on Feb. 2, 1959. He was 51 years of age.

A native of Maryland, Dr. Eichert was born in Baltimore on May 28, 1907. He was granted the B.S. degree in 1928 by the University of Maryland and in 1932 was awarded the M.D. degree by the School of Medicine of that institution. After serving internships at the Union Memorial Hospital and the Johns Hopkins Hospital in Baltimore from 1932 to 1934, he served a residency at the American Hospital in Paris, France, from 1934 to 1935. Upon his return to the United States, he completed a senior residency in medicine at the Johns Hopkins Hospital in 1936.

Dr. Eichert entered the private practice of medicine in Miami in 1937 and continued to practice there until 1942 when he enlisted in the Medical Corps of the United States Navy. He served as the attending cardiologist at the United States Naval Hospital No. 10 for three years and was discharged from military duty in 1945 with the rank of lieutenant commander. Returning to Miami, he engaged in the practice of cardiology until his death.

Locally, this internationally known cardiologist and author of many articles on cardiology was a

(Continued on page 1486)

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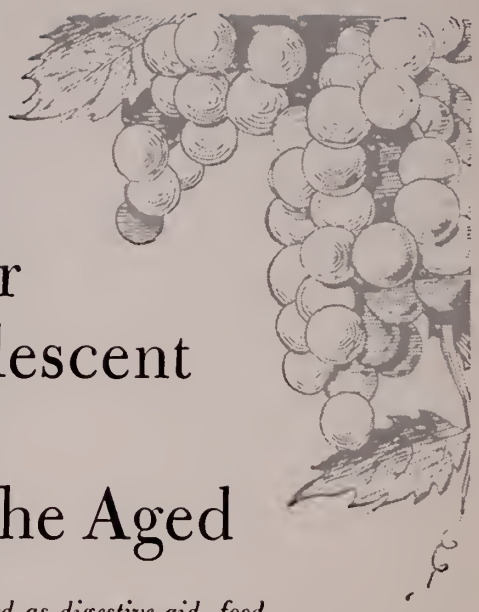


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(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

(2) Preisig, R., and Landman, M. E.: Am. Pract. & Digest Treat. *9*:740, 1958.

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(Continued from page 1480)

member of the board and chief of staff of the National Childrens' Cardiac Home, consultant in cardiology at the Veterans Administration Hospital, a past president and trustee of the Greater Miami Heart Association, one of the founders of the Miami Heart Institute, clinical associate professor of internal medicine and a former secretary of the medical board of the University of Miami School of Medicine, and a former director of cardiology at Jackson Memorial Hospital. In addition to serving on the staff of Jackson Memorial Hospital and Doctors' Hospital, he was chief of medicine at Mercy Hospital at the time of his death. An accomplished flyer, he made many trips to the far corners of the state and of the country and also to Canada, Cuba and South America to see patients and visit friends. He was co-chairman of the Florida Flying Physicians Association and a member of the Dade County Sheriff's Air Patrol.

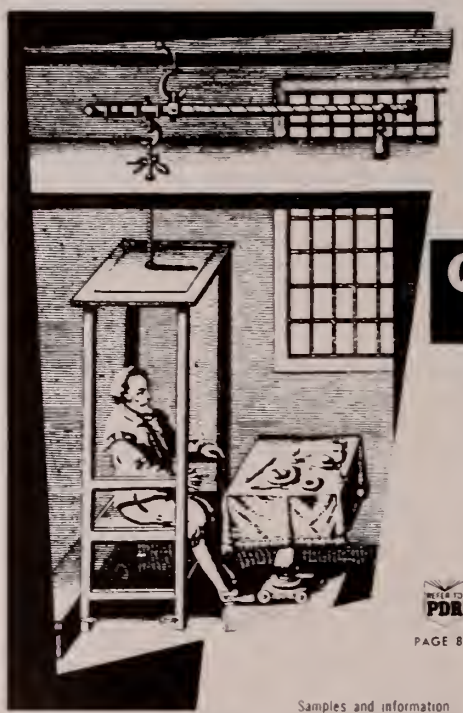
Dr. Eichert was a board member of the Dade County Medical Association, and a member of the Florida Medical Association and the American Medical Association. He was a former vice president of the American College of Cardiology, a member of the Scientific Assembly of the American Heart Association and a former vice president of the Florida Heart Association. A diplomate of the American Board of Internal Medicine and of the American Board of Cardiology, he was a fellow of the American College of Physicians and of the American College of Chest Physicians.

Surviving are the widow, the former Mary Ruth Warfield, and a daughter, Miss Mary Ruth Warfield Eichert, both of Miami, and a brother, Dr. Arnold Eichert, administrator of the South Florida Mental Hospital in West Hollywood.

Paul Kells

Dr. Paul Kells of Miami died on Dec. 29 1958, at Jackson Memorial Hospital in that city. He was 56 years of age.

A native of Pennsylvania, Dr. Kells was born in Meadville in 1902. He received his medical training at the University of Virginia School of Medicine and was awarded the degree of Doctor of Medicine by that institution in 1930. After completing graduate work in neurology and psychiatry, he came to Miami in 1933 from Wilming-



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References: 1. Charles, C. M.: Geriatrics 2:110 (March) 1956. 2. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956.

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ton, N. C., to engage in the private practice of that specialty and continued to practice there through the years. During World War II, he spent four years in military service in the United States Navy. In later years his career was hampered by illness. Through the formative years, however, he had a prominent role in the development of Miami's thriving medical community of today.

Locally, Dr. Kells was a founder of the Haven School for Retarded Children and was consulting psychiatrist to the University of Miami Guidance Clinic, the Dade County Courts and the Dade County Guidance Clinic. He was a member of the Military Order of World Wars, various bodies of the Masonic Lodge, the Shrine, the Miami Rotary Club, the Acacia Club and the Episcopal Church of the Resurrection.

Dr. Kells was a member of the Dade County Medical Association and since 1934 had held membership in the Florida Medical Association. He was also a member of the American Medical Association, the American Psychiatric Association and the Florida Psychiatric Society.

Surviving are the widow, Mrs. Beatrice Easton Kells, and a son, Willard Kells, of Miami.

BOOKS RECEIVED

Breast Cancer. *The Second Biennial Louisiana Cancer Conference.* Edited by Albert Segaloff, M.D. Pp. 257. Price, $5.00. St. Louis, The C. V. Mosby Company, 1958.

The Symposium which this book represents was organized as the Second Biennial Louisiana Cancer Conference under the aegis of the American Cancer Society, Louisiana Division, Inc. The unique features of breast cancer made it necessary to add to the experience of the pathologist, surgeon, and physician that of the endocrinologist, radiologist, epidemiologist, biochemist, zoologist, virologist, and psychiatrist. Distinguished representatives of each of these disciplines participated in the conference. An attempt was made to cover all important facets of the problem and to have formal presentations and free discussion as a forum for new ideas. All of this is included in the book.

Long-Term Illness. *Management of the Chronically Ill Patient.* Edited by Michael G. Wohl, M.D., F.A.C.P. With the Collaboration of Seventy-Nine Contributing Authorities. Pp. 748. Price, $17.00. Philadelphia, W. B. Saunders Company, 1959.

The aim of this book is to present in one volume a comprehensive survey of the management of the patient with prolonged illness. Rapid progress in the knowledge of disease and of the advances made in the last decade in the field of dynamic rehabilitation has made possible restoration of function to many patients with chronic illness and has brought many others to a higher level of self care. This volume represents the combined thinking and experience of many distinguished teachers and authorities in medicine and related fields. The book is designed primarily for the practicing physician who maintains an



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Among the distinguished contributors to the book are five members of the faculty of the University of Miami School of Medicine: Drs. Gus G. Casten, Jacob Colsky, Ralph Jones Jr., Ulfar Jonsson and E. Sterling Nichol.

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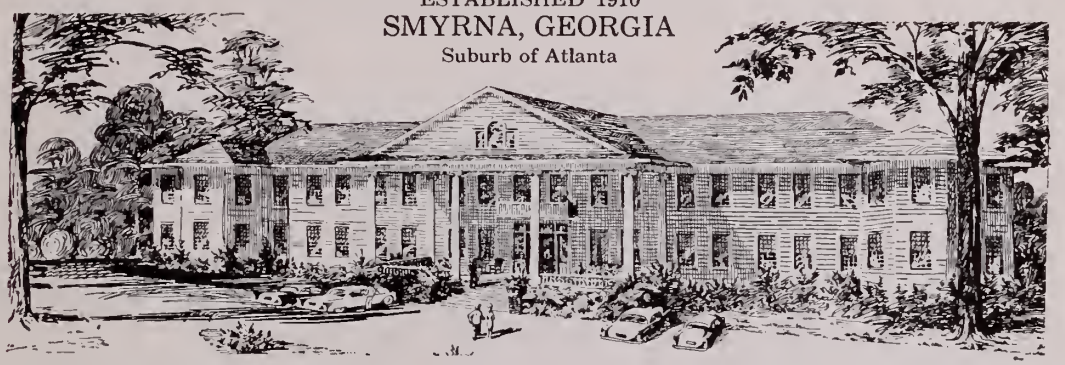
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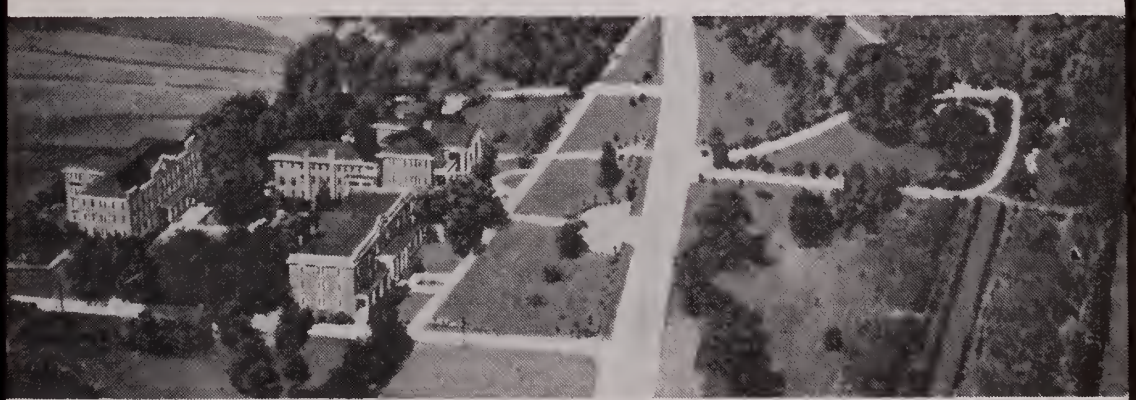
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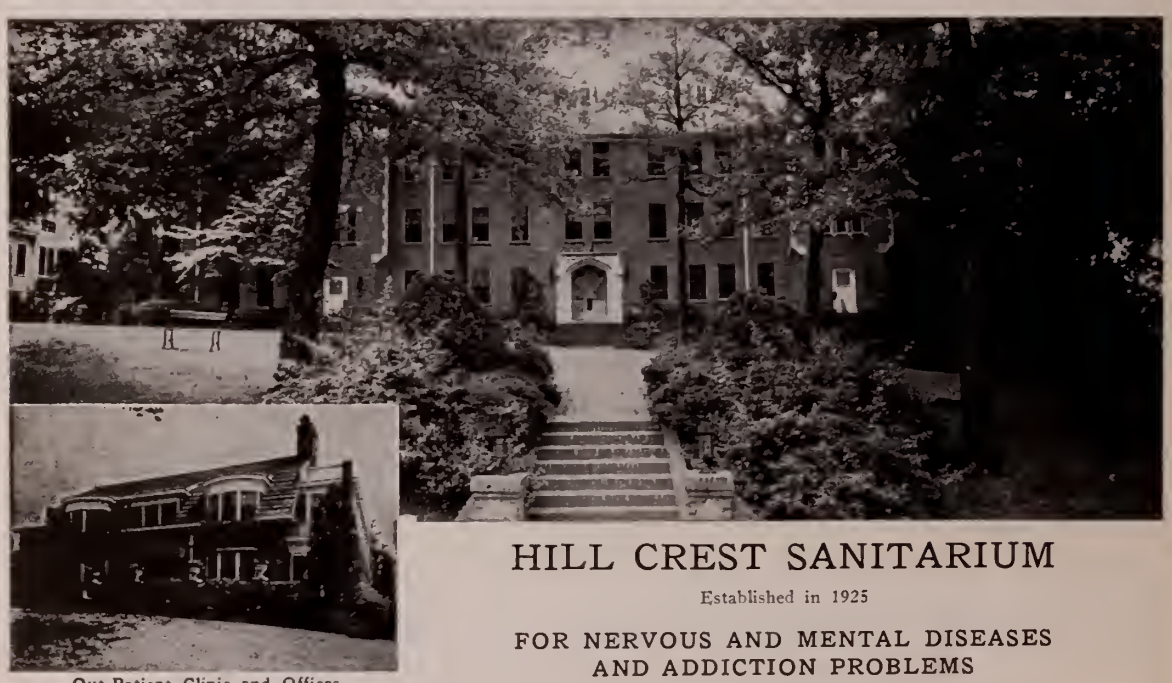
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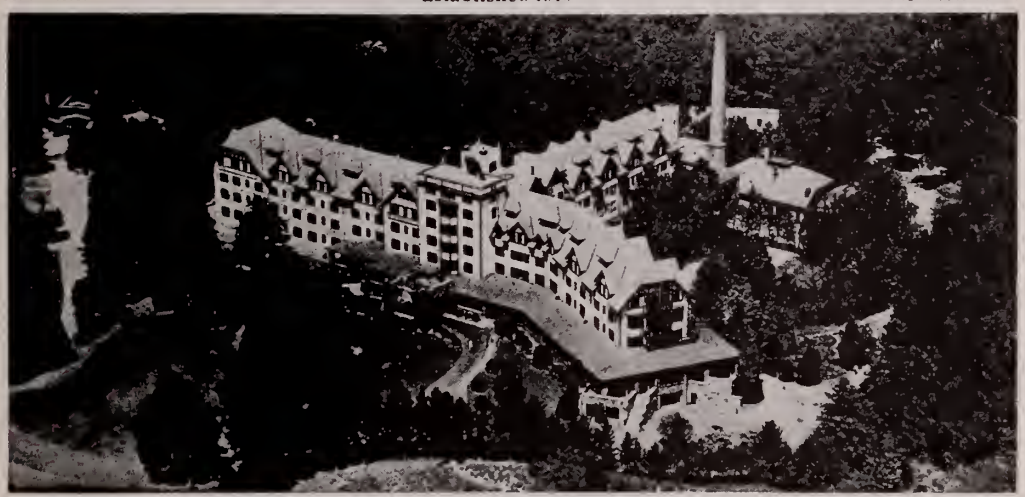
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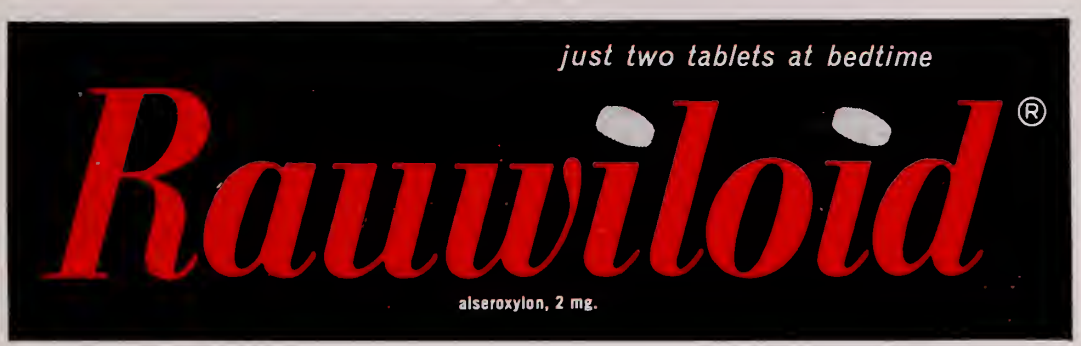
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Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* *Baker*				
Dade	Robert P. Keiser, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	954
DeSoto-Hardee-Highlands-Glades	James G. Smith, Wauchula	Miles A. Collier, Wauchula	1st Tues.	28
Duval	Samuel M. Day, Jacksonville	Ray O. Edwards Jr., Jacksonville	1st Tues.	361
* *Clay*				
Escambia	Egbert V. Anderson, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	117
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Hillsborough	Harold G. Nix, Tampa	Collin F. Baker Jr., Tampa	1st Tues.	243
Indian River	B. Bowman Guerin, Vero Beach	Emil D. Morgan, Vero Beach	2nd Tues.	12
Jackson-Calhoun	Glenn E. Padgett, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Frederick C. Andrews, Mt. Dora	Thomas D. Weaver, Clermont	1st Wed.	35
* *Sumter*				
Lee-Charlotte-Hendry	Wilson A. Rumberger, Ft. Myers	James C. Carver, Ft. Myers	3rd Mon.	43
Leon-Gadsden-Liberty-Wakulla-Jefferson	Hilliard R. Reddick, Quincy	Nelson H. Kraeft, Tallahassee	1st Mon.	81
Madison	Thomas G. Bouland Jr., Madison	Wilmer J. Coggins, Madison	Quarterly	7
Manatee	Irving E. Hall Jr., Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	39
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	35
* *Levy*				
Monroe	Joseph J. Scarlet, Key West	Herman K. Moore, Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	9
Orange	Robert L. Tolle, Orlando	Robert W. Curry, Orlando	3rd Wed.	246
* *Osceola*				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	176
Pasco-Hernando-Citrus	Alfred G. Brown Jr., Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Rowland E. Wood, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	309
Polk	Newell J. Griffith, Winter Haven	Clarence L. Anderson, Lakeland	2nd Wed.	139
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Robert F. Meeko, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Andrew J. Jesacher, Sarasota	George A. Bishopric, Sarasota	2nd Tues.	93
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	19
Suwannee-Hamilton-Lafayette	James F. Dietrich, Live Oak	Frederick T. Mickler Jr., Jasper	1st Sat.	10
Taylor	Ralph J. Greene, Perry	John A. Dyal Jr., Perry	Last Fri.	6
* *Dixie*				
Volusia	Alphonsus M. McCarthy, Daytona Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	100
* *Flagler*				
Walton-Okaloosa-Santa-Rosa	John C. Holley, Milton	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	34
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	6

* *Supervise and aid until organized separately.*

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